

PRELIMINARY DRAFT

TEXAS LEGISLATIVE COUNCIL  
Government Code  
Chapter 542  
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1 CHAPTER 542. SYSTEM REDESIGN FOR DELIVERY OF MEDICAID ACUTE CARE  
2 SERVICES AND LONG-TERM SERVICES AND SUPPORTS TO INDIVIDUALS WITH AN  
3 INTELLECTUAL OR DEVELOPMENTAL DISABILITY  
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12 CHAPTER 542. SYSTEM REDESIGN FOR DELIVERY OF MEDICAID ACUTE CARE  
13 SERVICES AND LONG-TERM SERVICES AND SUPPORTS TO INDIVIDUALS WITH AN  
14 INTELLECTUAL OR DEVELOPMENTAL DISABILITY

15 SUBCHAPTER A. GENERAL PROVISIONS

16 Revised Law

17 Sec. 542.0001. DEFINITIONS. In this chapter:

18 (1) "Advisory committee" means the intellectual and  
19 developmental disability system redesign advisory committee  
20 established under Section 542.0052.

21 (2) "Basic attendant service" means a service provided  
22 to an individual to assist the individual with an activity of daily  
23 living, including an instrumental activity of daily living, because  
24 of a physical, cognitive, or behavioral limitation related to the  
25 individual's disability or chronic health condition.

26 (3) "Comprehensive long-term services and supports  
27 provider" means a provider of long-term services and supports under  
28 this chapter that ensures the coordinated, seamless delivery of the  
29 full range of services in a recipient's program plan. The term  
30 includes:

- 31 (A) an ICF-IID program provider; and
- 32 (B) a Medicaid waiver program provider.

33 (4) "Consumer direction model" has the meaning  
34 assigned by Section \_\_\_\_\_ [[[Section 531.051]]].

1           (5) "Functional need" means the measurement of an  
2 individual's services and supports needs, including the  
3 individual's intellectual, psychiatric, medical, and physical  
4 support needs.

5           (6) "Habilitation service" includes a service  
6 provided to an individual to assist the individual with acquiring,  
7 retaining, or improving:

8           (A) a skill related to the activities of daily  
9 living; and

10           (B) the social and adaptive skills necessary for  
11 the individual to live and fully participate in the community.

12           (7) "ICF-IID" means the Medicaid program serving  
13 individuals with an intellectual or developmental disability who  
14 receive care in intermediate care facilities other than a state  
15 supported living center.

16           (8) "ICF-IID program" means a Medicaid program serving  
17 individuals with an intellectual or developmental disability who  
18 reside in and receive care from:

19           (A) an intermediate care facility licensed under  
20 Chapter 252, Health and Safety Code; or

21           (B) a community-based intermediate care facility  
22 operated by a local intellectual and developmental disability  
23 authority.

24           (9) "Local intellectual and developmental disability  
25 authority" has the meaning assigned by Section 531.002, Health and  
26 Safety Code.

27           (10) "Managed care organization" has the meaning  
28 assigned by Section \_\_\_\_\_ [[[Section 536.001]]].

29           (11) "Medicaid waiver program" means only the  
30 following programs that are authorized under Section 1915(c) of the  
31 Social Security Act (42 U.S.C. Section 1396n(c)) for the provision  
32 of services to individuals with an intellectual or developmental  
33 disability:

34           (A) the community living assistance and support

1 services (CLASS) waiver program;  
2 (B) the home and community-based services (HCS)  
3 waiver program;  
4 (C) the deaf-blind with multiple disabilities  
5 (DBMD) waiver program; and  
6 (D) the Texas home living (TxHmL) waiver program.  
7 (12) "Potentially preventable event" has the meaning  
8 assigned by Section \_\_\_\_ [[[Section 536.001]]].  
9 (13) "Residential service" means a service provided to  
10 an individual with an intellectual or developmental disability  
11 through a community-based ICF-IID, three- or four-person home or  
12 host home setting under the home and community-based services (HCS)  
13 waiver program, or a group home under the deaf-blind with multiple  
14 disabilities (DBMD) waiver program.  
15 (14) "State supported living center" has the meaning  
16 assigned by Section 531.002, Health and Safety Code. (Gov. Code,  
17 Sec. 534.001 (part).)

18 Source Law

19 Sec. 534.001. DEFINITIONS. In this chapter:

20 (1) "Advisory committee" means the  
21 Intellectual and Developmental Disability System  
22 Redesign Advisory Committee established under Section  
23 534.053.

24 (2) "Basic attendant services" means  
25 assistance with the activities of daily living,  
26 including instrumental activities of daily living,  
27 provided to an individual because of a physical,  
28 cognitive, or behavioral limitation related to the  
29 individual's disability or chronic health condition.

30 (3) "Comprehensive long-term services and  
31 supports provider" means a provider of long-term  
32 services and supports under this chapter that ensures  
33 the coordinated, seamless delivery of the full range  
34 of services in a recipient's program plan. The term  
35 includes:

36 (A) a provider under the ICF-IID  
37 program; and

38 (B) a provider under a Medicaid  
39 waiver program.

40 (3-a) "Consumer direction model" has the  
41 meaning assigned by Section 531.051.

42 (4) "Functional need" means the  
43 measurement of an individual's services and supports  
44 needs, including the individual's intellectual,  
45 psychiatric, medical, and physical support needs.

46 (5) "Habilitation services" includes  
47 assistance provided to an individual with acquiring,  
48 retaining, or improving:

49 (A) skills related to the activities

1 of daily living; and

2 (B) the social and adaptive skills  
3 necessary to enable the individual to live and fully  
4 participate in the community.

5 (6) "ICF-IID" means the program under  
6 Medicaid serving individuals with an intellectual or  
7 developmental disability who receive care in  
8 intermediate care facilities other than a state  
9 supported living center.

10 (7) "ICF-IID program" means a program  
11 under Medicaid serving individuals with an  
12 intellectual or developmental disability who reside in  
13 and receive care from:

14 (A) intermediate care facilities  
15 licensed under Chapter 252, Health and Safety Code; or

16 (B) community-based intermediate  
17 care facilities operated by local intellectual and  
18 developmental disability authorities.

19 (8) "Local intellectual and developmental  
20 disability authority" has the meaning assigned by  
21 Section 531.002, Health and Safety Code.

22 (9) "Managed care organization," . . . and  
23 "potentially preventable event" have the meanings  
24 assigned under Section 536.001.

25 (11) "Medicaid waiver program" means only  
26 the following programs that are authorized under  
27 Section 1915(c) of the federal Social Security Act (42  
28 U.S.C. Section 1396n(c)) for the provision of services  
29 to persons with an intellectual or developmental  
30 disability:

31 (A) the community living assistance  
32 and support services (CLASS) waiver program;

33 (B) the home and community-based  
34 services (HCS) waiver program;

35 (C) the deaf-blind with multiple  
36 disabilities (DBMD) waiver program; and

37 (D) the Texas home living (TxHmL)  
38 waiver program.

39 (11-a) "Residential services" means  
40 services provided to an individual with an  
41 intellectual or developmental disability through a  
42 community-based ICF-IID, three- or four-person home or  
43 host home setting under the home and community-based  
44 services (HCS) waiver program, or a group home under  
45 the deaf-blind with multiple disabilities (DBMD)  
46 waiver program.

47 (12) "State supported living center" has  
48 the meaning assigned by Section 531.002, Health and  
49 Safety Code.

50 Revisor's Note

51 Section 534.001(9), Government Code, defines  
52 "managed care plan" for purposes of Chapter 534,  
53 Government Code, which is revised as this chapter. The  
54 revised law omits the definition as unnecessary  
55 because the term is not used elsewhere in Chapter 534.

56 The omitted law reads:

57 (9) ["Managed care  
58 organization,"] "managed care plan," [and  
59 potentially preventable event" have the  
60 meanings assigned under Section 536.001.]

1 Revised Law

2 Sec. 542.0002. CONFLICT WITH OTHER LAW. To the extent of a  
3 conflict between a provision of this chapter and another state law,  
4 the provision of this chapter controls. (Gov. Code, Sec. 534.002.)

5 Source Law

6 Sec. 534.002. CONFLICT WITH OTHER LAW. To the  
7 extent of a conflict between a provision of this  
8 chapter and another state law, the provision of this  
9 chapter controls.

10 Revised Law

11 Sec. 542.0003. DELAYED IMPLEMENTATION AUTHORIZED.  
12 Notwithstanding any other law, the commission may delay  
13 implementing a provision of this chapter without additional  
14 investigation, adjustment, or legislative action if the commission  
15 determines implementing the provision would adversely affect the  
16 system of services and supports to persons and programs to which  
17 this chapter applies. (Gov. Code, Sec. 534.251.)

18 Source Law

19 Sec. 534.251. DELAYED IMPLEMENTATION  
20 AUTHORIZED. Notwithstanding any other law, the  
21 commission may delay implementation of a provision of  
22 this chapter without further investigation,  
23 adjustments, or legislative action if the commission  
24 determines the provision adversely affects the system  
25 of services and supports to persons and programs to  
26 which this chapter applies.

27 SUBCHAPTER B. ACUTE CARE SERVICES AND LONG-TERM SERVICES AND  
28 SUPPORTS SYSTEM REDESIGN

29 Revised Law

30 Sec. 542.0051. REDESIGN OF ACUTE CARE SERVICES AND  
31 LONG-TERM SERVICES AND SUPPORTS SYSTEM FOR INDIVIDUALS WITH AN  
32 INTELLECTUAL OR DEVELOPMENTAL DISABILITY. The commission shall  
33 design and implement an acute care services and long-term services  
34 and supports system for individuals with an intellectual or  
35 developmental disability that supports the following goals:

36 (1) provide Medicaid services to more individuals in a  
37 cost-efficient manner by providing the type and amount of services  
38 most appropriate to an individual's needs and preferences in the  
39 most integrated and least restrictive setting;



1 supports the following goals:

2 (1) provide Medicaid services to more  
3 individuals in a cost-efficient manner by providing  
4 the type and amount of services most appropriate to the  
5 individuals' needs and preferences in the most  
6 integrated and least restrictive setting;

7 (2) improve individuals' access to  
8 services and supports by ensuring that the individuals  
9 receive information about all available programs and  
10 services, including employment and least restrictive  
11 housing assistance, and how to apply for the programs  
12 and services;

13 (3) improve the assessment of individuals'  
14 needs and available supports, including the assessment  
15 of individuals' functional needs;

16 (4) promote person-centered planning,  
17 self-direction, self-determination, community  
18 inclusion, and customized, integrated, competitive  
19 employment;

20 (5) promote individualized budgeting  
21 based on an assessment of an individual's needs and  
22 person-centered planning;

23 (6) promote integrated service  
24 coordination of acute care services and long-term  
25 services and supports;

26 (7) improve acute care and long-term  
27 services and supports outcomes, including reducing  
28 unnecessary institutionalization and potentially  
29 preventable events;

30 (8) promote high-quality care;

31 (9) provide fair hearing and appeals  
32 processes in accordance with applicable federal law;

33 (10) ensure the availability of a local  
34 safety net provider and local safety net services;

35 (11) promote independent service  
36 coordination and independent ombudsmen services; and

37 (12) ensure that individuals with the most  
38 significant needs are appropriately served in the  
39 community and that processes are in place to prevent  
40 inappropriate institutionalization of individuals.

41 Revised Law

42 Sec. 542.0052. INTELLECTUAL AND DEVELOPMENTAL DISABILITY  
43 SYSTEM REDESIGN ADVISORY COMMITTEE. (a) The intellectual and  
44 developmental disability system redesign advisory committee shall  
45 advise the commission on implementing the acute care services and  
46 long-term services and supports system redesign under this chapter.

47 (b) The executive commissioner shall appoint stakeholders  
48 from the intellectual and developmental disabilities community to  
49 serve as advisory committee members, including:

50 (1) individuals with an intellectual or developmental  
51 disability who receive services under a Medicaid waiver program;

52 (2) individuals with an intellectual or developmental  
53 disability who receive services under an ICF-IID program;

54 (3) representatives who are advocates for individuals

1 described by Subdivisions (1) and (2), including at least three  
2 representatives from intellectual and developmental disability  
3 advocacy organizations;

4 (4) representatives of Medicaid managed care and  
5 nonmanaged care health care providers, including:

6 (A) physicians who are primary care providers;

7 (B) physicians who are specialty care providers;

8 (C) nonphysician mental health professionals;

9 and

10 (D) long-term services and supports providers,  
11 including direct service workers;

12 (5) representatives of entities with responsibilities  
13 for delivering Medicaid long-term services and supports or for  
14 other Medicaid service delivery, including:

15 (A) representatives of aging and disability  
16 resource centers established under the Aging and Disability  
17 Resource Center initiative funded in part by the Administration on  
18 Aging and the Centers for Medicare and Medicaid Services;

19 (B) representatives of community mental health  
20 and intellectual disability centers;

21 (C) representatives of and service coordinators  
22 or case managers from private and public home and community-based  
23 services providers that serve individuals with an intellectual or  
24 developmental disability; and

25 (D) representatives of private and public  
26 ICF-IID providers; and

27 (6) representatives of managed care organizations  
28 that contract with this state to provide services to individuals  
29 with an intellectual or developmental disability.

30 (c) To the greatest extent possible, the executive  
31 commissioner shall appoint members to the advisory committee who  
32 reflect the geographic diversity of this state and include members  
33 who represent rural Medicaid recipients.

34 (d) The executive commissioner shall appoint the presiding

1 officer of the advisory committee.

2 (e) The advisory committee must meet at least quarterly or  
3 more frequently if the presiding officer determines that more  
4 frequent meetings are necessary to address planning and development  
5 needs related to implementation of the acute care services and  
6 long-term services and supports system. The advisory committee may  
7 establish work groups that meet at other times to study and make  
8 recommendations on issues the advisory committee considers  
9 appropriate.

10 (f) An advisory committee member serves without  
11 compensation. An advisory committee member who is a Medicaid  
12 recipient or the relative of a Medicaid recipient is entitled to a  
13 per diem allowance and reimbursement at rates established in the  
14 General Appropriations Act.

15 (g) Chapter 551 applies to the advisory committee.

16 (h) On the second anniversary of the date the commission  
17 completes implementation of the transition required under Section  
18 542.0201:

- 19 (1) the advisory committee is abolished; and  
20 (2) this section expires. (Gov. Code, Sec. 534.053.)

21 Source Law

22 Sec. 534.053. INTELLECTUAL AND DEVELOPMENTAL  
23 DISABILITY SYSTEM REDESIGN ADVISORY COMMITTEE.

24 (a) The Intellectual and Developmental Disability  
25 System Redesign Advisory Committee shall advise the  
26 commission on the implementation of the acute care  
27 services and long-term services and supports system  
28 redesign under this chapter. Subject to Subsection  
29 (b), the executive commissioner shall appoint members  
30 of the advisory committee who are stakeholders from  
31 the intellectual and developmental disabilities  
32 community, including:

33 (1) individuals with an intellectual or  
34 developmental disability who are recipients of  
35 services under the Medicaid waiver programs,  
36 individuals with an intellectual or developmental  
37 disability who are recipients of services under the  
38 ICF-IID program, and individuals who are advocates of  
39 those recipients, including at least three  
40 representatives from intellectual and developmental  
41 disability advocacy organizations;

42 (2) representatives of Medicaid managed  
43 care and nonmanaged care health care providers,  
44 including:

45 (A) physicians who are primary care  
46 providers and physicians who are specialty care

1 providers;  
2 (B) nonphysician mental health  
3 professionals; and

4 (C) providers of long-term services  
5 and supports, including direct service workers;

6 (3) representatives of entities with  
7 responsibilities for the delivery of Medicaid  
8 long-term services and supports or other Medicaid  
9 service delivery, including:

10 (A) representatives of aging and  
11 disability resource centers established under the  
12 Aging and Disability Resource Center initiative funded  
13 in part by the federal Administration on Aging and the  
14 Centers for Medicare and Medicaid Services;

15 (B) representatives of community  
16 mental health and intellectual disability centers;

17 (C) representatives of and service  
18 coordinators or case managers from private and public  
19 home and community-based services providers that serve  
20 individuals with an intellectual or developmental  
21 disability; and

22 (D) representatives of private and  
23 public ICF-IID providers; and

24 (4) representatives of managed care  
25 organizations contracting with the state to provide  
26 services to individuals with an intellectual or  
27 developmental disability.

28 (b) To the greatest extent possible, the  
29 executive commissioner shall appoint members of the  
30 advisory committee who reflect the geographic  
31 diversity of the state and include members who  
32 represent rural Medicaid recipients.

33 (c) The executive commissioner shall appoint  
34 the presiding officer of the advisory committee.

35 (d) The advisory committee must meet at least  
36 quarterly or more frequently if the presiding officer  
37 determines that it is necessary to address planning  
38 and development needs related to implementation of the  
39 acute care services and long-term services and  
40 supports system.

41 (e) A member of the advisory committee serves  
42 without compensation. A member of the advisory  
43 committee who is a Medicaid recipient or the relative  
44 of a Medicaid recipient is entitled to a per diem  
45 allowance and reimbursement at rates established in  
46 the General Appropriations Act.

47 (e-1) The advisory committee may establish work  
48 groups that meet at other times for purposes of  
49 studying and making recommendations on issues the  
50 committee considers appropriate.

51 (f) The advisory committee is subject to the  
52 requirements of Chapter 551.

53 (g) On the second anniversary of the date the  
54 commission completes implementation of the transition  
55 required under Section 534.202:

56 (1) the advisory committee is abolished;  
57 and

58 (2) this section expires.

59 Revisor's Note

60 (1) Section 534.053(a), Government Code,  
61 requires the executive commissioner of the Health and  
62 Human Services Commission to appoint members of the  
63 intellectual and developmental disability system

1 redesign advisory committee "[s]ubject to Subsection  
2 (b)" of Section 534.053, Government Code. The revised  
3 law omits the quoted phrase as unnecessary because the  
4 requirements of Subsection (b), which is revised as  
5 Subsection (c) of this section, apply by their own  
6 terms.

7 (2) Section 534.053(g), Government Code, refers  
8 to the transition required under Section 534.202,  
9 Government Code. The provisions of Section 534.202  
10 requiring the implementation of a transition are  
11 revised in this chapter as Section 542.0201, and the  
12 revised law is drafted accordingly.

13 Revised Law

14 Sec. 542.0053. IMPLEMENTATION OF SYSTEM REDESIGN. The  
15 commission shall, in collaboration with the advisory committee,  
16 implement the acute care services and long-term services and  
17 supports system for individuals with an intellectual or  
18 developmental disability in the manner and in the stages described  
19 by this chapter. (Gov. Code, Sec. 534.052.)

20 Source Law

21 Sec. 534.052. IMPLEMENTATION OF SYSTEM  
22 REDESIGN. The commission shall, in consultation and  
23 collaboration with the advisory committee, implement  
24 the acute care services and long-term services and  
25 supports system for individuals with an intellectual  
26 or developmental disability in the manner and in the  
27 stages described in this chapter.

28 Revisor's Note

29 Section 534.052, Government Code, provides that  
30 the Health and Human Services Commission shall take  
31 certain action in "consultation and collaboration"  
32 with an advisory committee. Throughout this chapter,  
33 the revised law omits "consultation" in this context  
34 as redundant because "consultation" is included within  
35 the meaning of "collaboration."

36 Revised Law

37 Sec. 542.0054. ANNUAL REPORT ON IMPLEMENTATION. (a) Not

1 later than September 30 of each year, the commission, in  
2 collaboration with the advisory committee, shall prepare and submit  
3 to the legislature a report that includes:

4 (1) an assessment of the implementation of the system  
5 required by this chapter, including appropriate information  
6 regarding the provision of acute care services and long-term  
7 services and supports to individuals with an intellectual or  
8 developmental disability under Medicaid;

9 (2) recommendations regarding implementation of and  
10 improvements to the system redesign, including recommendations  
11 regarding appropriate statutory changes to facilitate the  
12 implementation; and

13 (3) an assessment of the effect of the system on:

14 (A) access to long-term services and supports;

15 (B) the quality of acute care services and  
16 long-term services and supports;

17 (C) meaningful outcomes for Medicaid recipients  
18 using person-centered planning, individualized budgeting, and  
19 self-determination, including an individual's inclusion in the  
20 community;

21 (D) the integration of service coordination of  
22 acute care services and long-term services and supports;

23 (E) the efficiency and use of funding;

24 (F) the placement of individuals in housing that  
25 is the least restrictive setting appropriate to an individual's  
26 needs;

27 (G) employment assistance and customized,  
28 integrated, competitive employment options; and

29 (H) the number and types of fair hearing and  
30 appeals processes in accordance with federal law.

31 (b) This section expires on the second anniversary of the  
32 date the commission completes implementation of the transition  
33 required under Section 542.0201. (Gov. Code, Sec. 534.054.)

1 Source Law

2 Sec. 534.054. ANNUAL REPORT ON IMPLEMENTATION.  
3 (a) Not later than September 30 of each year, the  
4 commission, in consultation and collaboration with the  
5 advisory committee, shall prepare and submit a report  
6 to the legislature that must include:

7 (1) an assessment of the implementation of  
8 the system required by this chapter, including  
9 appropriate information regarding the provision of  
10 acute care services and long-term services and  
11 supports to individuals with an intellectual or  
12 developmental disability under Medicaid as described  
13 by this chapter;

14 (2) recommendations regarding  
15 implementation of and improvements to the system  
16 redesign, including recommendations regarding  
17 appropriate statutory changes to facilitate the  
18 implementation; and

19 (3) an assessment of the effect of the  
20 system on the following:

21 (A) access to long-term services and  
22 supports;

23 (B) the quality of acute care  
24 services and long-term services and supports;

25 (C) meaningful outcomes for Medicaid  
26 recipients using person-centered planning,  
27 individualized budgeting, and self-determination,  
28 including a person's inclusion in the community;

29 (D) the integration of service  
30 coordination of acute care services and long-term  
31 services and supports;

32 (E) the efficiency and use of  
33 funding;

34 (F) the placement of individuals in  
35 housing that is the least restrictive setting  
36 appropriate to an individual's needs;

37 (G) employment assistance and  
38 customized, integrated, competitive employment  
39 options; and

40 (H) the number and types of fair  
41 hearing and appeals processes in accordance with  
42 applicable federal law.

43 (b) This section expires on the second  
44 anniversary of the date the commission completes  
45 implementation of the transition required under  
46 Section 534.202.

47 Revisor's Note

48 Section 534.054(b), Government Code, refers to  
49 the transition required under Section 534.202,  
50 Government Code. The revised law substitutes a  
51 reference to Section 542.0201 of this chapter for the  
52 reason stated in Revisor's Note (2) to Section 542.0052  
53 of this chapter.

54 SUBCHAPTER C. STAGE ONE: PILOT PROGRAM FOR IMPROVING SERVICE  
55 DELIVERY MODELS

1 Revised Law

2 Sec. 542.0101. DEFINITIONS. In this subchapter:

3 (1) "Capitation" means a method of compensating a  
4 provider on a monthly basis for providing or coordinating the  
5 provision of a defined set of services and supports that is based on  
6 a predetermined payment per services recipient.

7 (2) "Pilot program" means the pilot program  
8 established under this subchapter.

9 (3) "Pilot program participant" means an individual  
10 who is enrolled in and receives services through the pilot program.

11 (4) "Pilot program work group" means the pilot program  
12 work group established under Section 542.0104. (Gov. Code, Sec.  
13 534.101; New.)

14 Source Law

15 Sec. 534.101. DEFINITIONS. In this subchapter:

16 (1) "Capitation" means a method of  
17 compensating a provider on a monthly basis for  
18 providing or coordinating the provision of a defined  
19 set of services and supports that is based on a  
20 predetermined payment per services recipient.

21 (2) "Pilot program" means the pilot  
22 program established under this subchapter.

23 (3) "Pilot program workgroup" means the  
24 pilot program workgroup established under Section  
25 534.1015.

26 Revisor's Note

27 (1) Section 534.101, Government Code, defines  
28 terms for purposes of "this subchapter," meaning  
29 Subchapter C, Chapter 534. The provisions of  
30 Subchapter C, Chapter 534, are revised in this  
31 subchapter. This subchapter of the revised law also  
32 includes the revision of Section 534.252, Government  
33 Code, which is a provision of Subchapter F, Chapter  
34 534, Government Code. The revised law retains the  
35 reference to "this subchapter" and applies the  
36 definitions included in this section of the revised  
37 law to the revision of Section 534.252, Government  
38 Code, because, to the extent those terms are used in  
39 the revision of Section 534.252, the terms have the

1 same meanings as defined by this section.

2 (2) The revised law adds a definition of "pilot  
3 program participant" for drafting convenience and to  
4 avoid frequent, unnecessary repetition of the  
5 substance of the definition.

6 Revised Law

7 Sec. 542.0102. PILOT PROGRAM TO TEST PERSON-CENTERED  
8 MANAGED CARE STRATEGIES AND IMPROVEMENTS BASED ON CAPITATION. (a)  
9 The commission, in collaboration with the advisory committee and  
10 pilot program work group, shall develop and implement a pilot  
11 program to test the delivery of long-term services and supports to  
12 pilot program participants through the STAR+PLUS Medicaid managed  
13 care program.

14 (b) A managed care organization participating in the pilot  
15 program shall provide Medicaid long-term services and supports to  
16 individuals with an intellectual or developmental disability and  
17 individuals with similar functional needs to test the  
18 organization's managed care strategy based on capitation.

19 (c) The pilot program must be designed to:

20 (1) increase access to long-term services and  
21 supports;

22 (2) improve the quality of acute care services and  
23 long-term services and supports;

24 (3) promote:

25 (A) informed choice and meaningful outcomes by  
26 using person-centered planning, flexible consumer-directed  
27 services, individualized budgeting, and self-determination; and

28 (B) community inclusion and engagement;

29 (4) promote integrated service coordination of acute  
30 care services and long-term services and supports;

31 (5) promote efficiency and best funding use based on a  
32 pilot program participant's needs and preferences;

33 (6) promote, through housing supports and navigation  
34 services, stability in housing that is the most integrated and

1 least restrictive based on a pilot program participant's needs and  
2 preferences;

3 (7) promote employment assistance and customized,  
4 integrated, competitive employment;

5 (8) provide fair hearing and appeals processes in  
6 accordance with federal and state law;

7 (9) promote the use of innovative technologies and  
8 benefits, including telemedicine, telemonitoring, the testing of  
9 remote monitoring, transportation services, and other innovations  
10 that support community integration;

11 (10) ensure a provider network that is adequate and  
12 includes comprehensive long-term services and supports providers  
13 and ensure that pilot program participants have a choice among  
14 those providers;

15 (11) ensure the timely initiation and consistent  
16 provision of long-term services and supports in accordance with a  
17 pilot program participant's person-centered plan;

18 (12) ensure that pilot program participants with  
19 complex behavioral, medical, and physical needs are assessed and  
20 receive appropriate services in the most integrated and least  
21 restrictive setting based on the participants' needs and  
22 preferences;

23 (13) increase access to, expand flexibility of, and  
24 promote the use of the consumer direction model;

25 (14) promote independence, self-determination, the  
26 use of the consumer direction model, and decision making by pilot  
27 program participants by using alternatives to guardianship,  
28 including a supported decision-making agreement as defined by  
29 Section 1357.002, Estates Code; and

30 (15) promote sufficient flexibility to achieve,  
31 through the pilot program, the goals listed in:

32 (A) this subsection;

33 (B) Subsection (b); and

34 (C) Sections 542.0103, 542.0110(a), 542.0113,

1 and 542.0116(c). (Gov. Code, Secs. 534.102, 534.104(a), (h).)

2 Source Law

3 Sec. 534.102. PILOT PROGRAM TO TEST  
4 PERSON-CENTERED MANAGED CARE STRATEGIES AND  
5 IMPROVEMENTS BASED ON CAPITATION. The commission, in  
6 consultation and collaboration with the advisory  
7 committee and pilot program workgroup, shall develop  
8 and implement a pilot program in accordance with this  
9 subchapter to test, through the STAR+PLUS Medicaid  
10 managed care program, the delivery of long-term  
11 services and supports to individuals participating in  
12 the pilot program.

13 Sec. 534.104. PILOT PROGRAM DESIGN. (a) The  
14 pilot program must be designed to:

15 (1) increase access to long-term services  
16 and supports;

17 (2) improve quality of acute care services  
18 and long-term services and supports;

19 (3) promote:

20 (A) informed choice and meaningful  
21 outcomes by using person-centered planning, flexible  
22 consumer-directed services, individualized budgeting,  
23 and self-determination; and

24 (B) community inclusion and  
25 engagement;

26 (4) promote integrated service  
27 coordination of acute care services and long-term  
28 services and supports;

29 (5) promote efficiency and the best use of  
30 funding based on an individual's needs and  
31 preferences;

32 (6) promote through housing supports and  
33 navigation services stability in housing that is the  
34 most integrated and least restrictive based on the  
35 individual's needs and preferences;

36 (7) promote employment assistance and  
37 customized, integrated, and competitive employment;

38 (8) provide fair hearing and appeals  
39 processes in accordance with applicable federal and  
40 state law;

41 (9) promote sufficient flexibility to  
42 achieve the goals listed in this section through the  
43 pilot program;

44 (10) promote the use of innovative  
45 technologies and benefits, including telemedicine,  
46 telemonitoring, the testing of remote monitoring,  
47 transportation services, and other innovations that  
48 support community integration;

49 (11) ensure an adequate provider network  
50 that includes comprehensive long-term services and  
51 supports providers and ensure that pilot program  
52 participants have a choice among those providers;

53 (12) ensure the timely initiation and  
54 consistent provision of long-term services and  
55 supports in accordance with an individual's  
56 person-centered plan;

57 (13) ensure that individuals with complex  
58 behavioral, medical, and physical needs are assessed  
59 and receive appropriate services in the most  
60 integrated and least restrictive setting based on the  
61 individuals' needs and preferences;

62 (14) increase access to, expand  
63 flexibility of, and promote the use of the consumer  
64 direction model; and

1 (15) promote independence,  
2 self-determination, the use of the consumer direction  
3 model, and decision making by individuals  
4 participating in the pilot program by using  
5 alternatives to guardianship, including a supported  
6 decision-making agreement as defined by Section  
7 1357.002, Estates Code.

8 (h) Under the pilot program, a participating  
9 managed care organization shall provide long-term  
10 services and supports under Medicaid to persons with  
11 an intellectual or developmental disability and  
12 persons with similar functional needs to test its  
13 managed care strategy based on capitation.

14 Revisor's Note

15 (1) Sections 534.102 and 534.104(a)(15),  
16 Government Code, refer to "individuals participating  
17 in the pilot program," meaning the pilot program  
18 implemented under Subchapter C, Chapter 534,  
19 Government Code, which is revised in this subchapter.  
20 Sections 534.104(a)(5), (6), (12), and (13),  
21 Government Code, specify certain goals of the pilot  
22 program in relation to individuals. Section 542.0101  
23 of this chapter defines "pilot program participant"  
24 for purposes of the subchapter, and the substance of  
25 that definition is synonymous with an "individual  
26 participating in the pilot program." Additionally,  
27 the pilot program goals relate only to individuals who  
28 receive services through the pilot program, and those  
29 individuals are pilot program participants. For  
30 clarity and consistency of terminology, the revised  
31 law substitutes "pilot program participant" or "pilot  
32 program participants," as appropriate, for the  
33 references to "individuals participating in the pilot  
34 program" or to an individual with respect to whom the  
35 pilot program is designed to achieve the specified  
36 goals. Similar changes are made throughout this  
37 subchapter where the context makes clear that a  
38 referenced individual is necessarily a pilot program  
39 participant.

40 (2) Section 534.104(a)(9), Government Code,

1 refers to goals listed in "this section," meaning  
2 Section 534.104, Government Code. The relevant  
3 provisions of Section 534.104 are revised in this  
4 section as Subsections (b) and (c) and elsewhere in  
5 this chapter as Sections 542.0103, 542.0110(a),  
6 542.0113, and 542.0116(c). The revised law is drafted  
7 accordingly.

8 Revised Law

9 Sec. 542.0103. ALTERNATIVE PAYMENT RATE OR METHODOLOGY.

10 (a) The pilot program must be designed to test the use of  
11 innovative payment rates and methodologies for the provision of  
12 long-term services and supports to achieve the goals of the pilot  
13 program. The payment methodologies must include:

14 (1) the payment of a bundled amount without downside  
15 risk to a comprehensive long-term services and supports provider  
16 for some or all services delivered as part of a comprehensive array  
17 of long-term services and supports;

18 (2) enhanced incentive payments to comprehensive  
19 long-term services and supports providers based on the completion  
20 of predetermined outcomes or quality metrics; and

21 (3) any other payment model the commission approves.

22 (b) An alternative payment rate or methodology may be used  
23 for a managed care organization and comprehensive long-term  
24 services and supports provider only if the organization and  
25 provider agree in advance and in writing to use the rate or  
26 methodology.

27 (c) In developing an alternative payment rate or  
28 methodology, the commission, managed care organizations, and  
29 comprehensive long-term services and supports providers shall  
30 consider:

31 (1) the historical costs of long-term services and  
32 supports, including Medicaid fee-for-service rates;

33 (2) reasonable cost estimates for new services under  
34 the pilot program; and

1 (3) whether an alternative payment rate or methodology  
2 is sufficient to promote quality outcomes and ensure a provider's  
3 continued participation in the pilot program.

4 (d) An alternative payment rate or methodology may not  
5 reduce the minimum payment a provider receives for delivering  
6 long-term services and supports under the pilot program to an  
7 amount that is less than the fee-for-service reimbursement rate the  
8 provider received for delivering those services before  
9 participating in the pilot program. (Gov. Code, Secs. 534.104(c),  
10 (d), (e), (f).)

11 Source Law

12 (c) The pilot program must be designed to test  
13 innovative payment rates and methodologies for the  
14 provision of long-term services and supports to  
15 achieve the goals of the pilot program by using payment  
16 methodologies that include:

17 (1) the payment of a bundled amount  
18 without downside risk to a comprehensive long-term  
19 services and supports provider for some or all  
20 services delivered as part of a comprehensive array of  
21 long-term services and supports;

22 (2) enhanced incentive payments to  
23 comprehensive long-term services and supports  
24 providers based on the completion of predetermined  
25 outcomes or quality metrics; and

26 (3) any other payment models approved by  
27 the commission.

28 (d) An alternative payment rate or methodology  
29 described by Subsection (c) may be used for a managed  
30 care organization and comprehensive long-term  
31 services and supports provider only if the  
32 organization and provider agree in advance and in  
33 writing to use the rate or methodology.

34 (e) In developing an alternative payment rate or  
35 methodology described by Subsection (c), the  
36 commission, managed care organizations, and  
37 comprehensive long-term services and supports  
38 providers shall consider:

39 (1) the historical costs of long-term  
40 services and supports, including Medicaid  
41 fee-for-service rates;

42 (2) reasonable cost estimates for new  
43 services under the pilot program; and

44 (3) whether an alternative payment rate or  
45 methodology is sufficient to promote quality outcomes  
46 and ensure a provider's continued participation in the  
47 pilot program.

48 (f) An alternative payment rate or methodology  
49 described by Subsection (c) may not reduce the minimum  
50 payment received by a provider for the delivery of  
51 long-term services and supports under the pilot  
52 program below the fee-for-service reimbursement rate  
53 received by the provider for the delivery of those  
54 services before participating in the pilot program.

1 Revised Law

2 Sec. 542.0104. PILOT PROGRAM WORK GROUP. (a) The executive  
3 commissioner, in consultation with the advisory committee, shall  
4 establish a pilot program work group to assist in developing and  
5 provide advice on the operation of the pilot program.

6 (b) The pilot program work group is composed of:

7 (1) representatives of the advisory committee;

8 (2) stakeholders representing individuals with an  
9 intellectual or developmental disability;

10 (3) stakeholders representing individuals with  
11 similar functional needs as the individuals described by  
12 Subdivision (2); and

13 (4) representatives of managed care organizations  
14 that contract with the commission to provide services under the  
15 STAR+PLUS Medicaid managed care program.

16 (c) Chapter 2110 applies to the pilot program work group.  
17 (Gov. Code, Sec. 534.1015.)

18 Source Law

19 Sec. 534.1015. PILOT PROGRAM WORKGROUP. (a)  
20 The executive commissioner, in consultation with the  
21 advisory committee, shall establish a pilot program  
22 workgroup to provide assistance in developing and  
23 advice concerning the operation of the pilot program.

24 (b) The pilot program workgroup is composed of:

25 (1) representatives of the advisory  
26 committee;

27 (2) stakeholders representing individuals  
28 with an intellectual or developmental disability;

29 (3) stakeholders representing individuals  
30 with similar functional needs as those individuals  
31 described by Subdivision (2); and

32 (4) representatives of managed care  
33 organizations that contract with the commission to  
34 provide services under the STAR+PLUS Medicaid managed  
35 care program.

36 (c) Chapter 2110 applies to the pilot program  
37 workgroup.

38 Revised Law

39 Sec. 542.0105. STAKEHOLDER INPUT. As part of developing  
40 and implementing the pilot program, the commission, in  
41 collaboration with the advisory committee and pilot program work  
42 group, shall develop a process to receive and evaluate:

43 (1) input from:

- 1 (A) statewide stakeholders; and  
2 (B) stakeholders from a STAR+PLUS Medicaid  
3 managed care service area in which the pilot program will be  
4 implemented; and  
5 (2) other evaluations and data. (Gov. Code, Sec.  
6 534.103.)

7 Source Law

8 Sec. 534.103. STAKEHOLDER INPUT. As part of  
9 developing and implementing the pilot program, the  
10 commission, in consultation and collaboration with the  
11 advisory committee and pilot program workgroup, shall  
12 develop a process to receive and evaluate:

13 (1) input from statewide stakeholders and  
14 stakeholders from a STAR+PLUS Medicaid managed care  
15 service area in which the pilot program will be  
16 implemented; and

17 (2) other evaluations and data.

18 Revised Law

19 Sec. 542.0106. MEASURABLE GOALS. (a) The commission, in  
20 collaboration with the advisory committee and pilot program work  
21 group, shall:

22 (1) identify, using national core indicators, the  
23 National Quality Forum long-term services and supports measures,  
24 and other appropriate Consumer Assessment of Healthcare Providers  
25 and Systems measures, measurable goals the pilot program is to  
26 achieve;

27 (2) develop specific strategies and performance  
28 measures for achieving the identified goals; and

29 (3) ensure that mechanisms to report, track, and  
30 assess specific strategies and performance measures for achieving  
31 the identified goals are established before implementing the pilot  
32 program.

33 (b) A strategy proposed under Subsection (a)(2) may be  
34 evidence-based if an evidence-based strategy is available for  
35 meeting the identified goals. (Gov. Code, Sec. 534.105.)

36 Source Law

37 Sec. 534.105. PILOT PROGRAM: MEASURABLE GOALS.  
38 (a) The commission, in consultation and collaboration  
39 with the advisory committee and pilot program  
40 workgroup and using national core indicators, the

1 National Quality Forum long-term services and supports  
2 measures, and other appropriate Consumer Assessment of  
3 Healthcare Providers and Systems measures, shall  
4 identify measurable goals to be achieved by the pilot  
5 program.

6 (b) The commission, in consultation and  
7 collaboration with the advisory committee and pilot  
8 program workgroup, shall develop specific strategies  
9 and performance measures for achieving the identified  
10 goals. A proposed strategy may be evidence-based if  
11 there is an evidence-based strategy available for  
12 meeting the pilot program's goals.

13 (c) The commission, in consultation and  
14 collaboration with the advisory committee and pilot  
15 program workgroup, shall ensure that mechanisms to  
16 report, track, and assess specific strategies and  
17 performance measures for achieving the identified  
18 goals are established before implementing the pilot  
19 program.

20 Revised Law

21 Sec. 542.0107. MANAGED CARE ORGANIZATION SELECTION. The  
22 commission shall:

23 (1) in collaboration with the advisory committee and  
24 pilot program work group, develop criteria regarding the selection  
25 of a managed care organization to participate in the pilot program;  
26 and

27 (2) select and contract with not more than two managed  
28 care organizations that contract with the commission to provide  
29 services under the STAR+PLUS Medicaid managed care program to  
30 participate in the pilot program. (Gov. Code, Sec. 534.1035.)

31 Source Law

32 Sec. 534.1035. MANAGED CARE ORGANIZATION  
33 SELECTION. (a) The commission, in consultation and  
34 collaboration with the advisory committee and pilot  
35 program workgroup, shall develop criteria regarding  
36 the selection of a managed care organization to  
37 participate in the pilot program.

38 (b) The commission shall select and contract  
39 with not more than two managed care organizations that  
40 contract with the commission to provide services under  
41 the STAR+PLUS Medicaid managed care program to  
42 participate in the pilot program.

43 Revised Law

44 Sec. 542.0108. MANAGED CARE ORGANIZATION PARTICIPATION  
45 REQUIREMENTS. The commission shall require that a managed care  
46 organization participating in the pilot program:

47 (1) ensures that pilot program participants have a  
48 choice among acute care and comprehensive long-term services and

1 supports providers and service delivery options, including the  
2 consumer direction model;

3 (2) demonstrates to the commission's satisfaction that  
4 the organization's network of acute care, long-term services and  
5 supports, and comprehensive long-term services and supports  
6 providers have experience and expertise in providing services for  
7 individuals with an intellectual or developmental disability and  
8 individuals with similar functional needs;

9 (3) has a process for preventing the inappropriate  
10 institutionalization of pilot program participants; and

11 (4) ensures the timely initiation and consistent  
12 provision of services in accordance with a pilot program  
13 participant's person-centered plan. (Gov. Code, Sec. 534.107(a).)

14 Source Law

15 Sec. 534.107. COMMISSION RESPONSIBILITIES. (a)  
16 The commission shall require that a managed care  
17 organization participating in the pilot program:

18 (1) ensures that individuals  
19 participating in the pilot program have a choice among  
20 acute care and comprehensive long-term services and  
21 supports providers and service delivery options,  
22 including the consumer direction model;

23 (2) demonstrates to the commission's  
24 satisfaction that the organization's network of acute  
25 care, long-term services and supports, and  
26 comprehensive long-term services and supports  
27 providers have experience and expertise in providing  
28 services for individuals with an intellectual or  
29 developmental disability and individuals with similar  
30 functional needs;

31 (3) has a process for preventing  
32 inappropriate institutionalizations of individuals;  
33 and

34 (4) ensures the timely initiation and  
35 consistent provision of services in accordance with an  
36 individual's person-centered plan.

37 Revised Law

38 Sec. 542.0109. REQUIRED BENEFITS. (a) The commission  
39 shall ensure that a managed care organization participating in the  
40 pilot program provides:

41 (1) all Medicaid state plan acute care benefits  
42 available under the STAR+PLUS Medicaid managed care program;

43 (2) long-term services and supports under the Medicaid  
44 state plan, including:

1 (A) Community First Choice services;  
2 (B) personal assistance services;  
3 (C) day activity health services; and  
4 (D) habilitation services;  
5 (3) long-term services and supports under the  
6 STAR+PLUS home and community-based services (HCBS) waiver program,  
7 including:

- 8 (A) assisted living services;
- 9 (B) personal assistance services;
- 10 (C) employment assistance;
- 11 (D) supported employment;
- 12 (E) adult foster care;
- 13 (F) dental care;
- 14 (G) nursing care;
- 15 (H) respite care;
- 16 (I) home-delivered meals;
- 17 (J) cognitive rehabilitative therapy;
- 18 (K) physical therapy;
- 19 (L) occupational therapy;
- 20 (M) speech-language pathology;
- 21 (N) medical supplies;
- 22 (O) minor home modifications; and
- 23 (P) adaptive aids;

24 (4) the following long-term services and supports  
25 under a Medicaid waiver program:

- 26 (A) enhanced behavioral health services;
- 27 (B) behavioral supports;
- 28 (C) day habilitation; and
- 29 (D) community support transportation;

30 (5) the following additional long-term services and  
31 supports:

- 32 (A) housing supports;
- 33 (B) behavioral health crisis intervention  
34 services; and

1 (C) high medical needs services;

2 (6) other nonresidential long-term services and  
3 supports that the commission, in collaboration with the advisory  
4 committee and pilot program work group, determines are appropriate  
5 and consistent with requirements governing the Medicaid waiver  
6 programs, person-centered approaches, home and community-based  
7 setting requirements, and achievement of the most integrated and  
8 least restrictive setting based on an individual's needs and  
9 preferences; and

10 (7) dental services benefits in accordance with  
11 Subsection (b).

12 (b) In developing the pilot program, the commission shall:

13 (1) evaluate dental services benefits provided  
14 through Medicaid waiver programs and dental services benefits  
15 provided as a value-added service under the Medicaid managed care  
16 delivery model;

17 (2) determine which dental services benefits are the  
18 most cost-effective in reducing emergency room and inpatient  
19 hospital admissions resulting from poor oral health; and

20 (3) based on the determination made under Subdivision  
21 (2), provide the most cost-effective dental services benefits to  
22 pilot program participants.

23 (c) Before implementing the pilot program, the commission,  
24 in collaboration with the advisory committee and pilot program work  
25 group, shall:

26 (1) for pilot program purposes only, develop  
27 recommendations to modify adult foster care and supported  
28 employment and employment assistance benefits to increase access to  
29 and availability of those services; and

30 (2) as necessary, define services listed under  
31 Subsections (a)(4) and (5) and any other services the commission  
32 determines to be appropriate under Subsection (a)(6). (Gov. Code,  
33 Secs. 534.1045(a), (a-1), (f).)

Source Law

1  
2           Sec. 534.1045. PILOT PROGRAM BENEFITS AND  
3 PROVIDER QUALIFICATIONS. (a) Subject to Subsection  
4 (b), the commission shall ensure that a managed care  
5 organization participating in the pilot program  
6 provides:

7           (1) all Medicaid state plan acute care  
8 benefits available under the STAR+PLUS Medicaid  
9 managed care program;

10           (2) long-term services and supports under  
11 the Medicaid state plan, including:

- 12                   (A) Community First Choice services;
- 13                   (B) personal assistance services;
- 14                   (C) day activity health services; and
- 15                   (D) habilitation services;

16           (3) long-term services and supports under  
17 the STAR+PLUS home and community-based services (HCBS)  
18 waiver program, including:

- 19                   (A) assisted living services;
- 20                   (B) personal assistance services;
- 21                   (C) employment assistance;
- 22                   (D) supported employment;
- 23                   (E) adult foster care;
- 24                   (F) dental care;
- 25                   (G) nursing care;
- 26                   (H) respite care;
- 27                   (I) home-delivered meals;
- 28                   (J) cognitive                   rehabilitative  
29 therapy;

- 30                   (K) physical therapy;
- 31                   (L) occupational therapy;
- 32                   (M) speech-language pathology;
- 33                   (N) medical supplies;
- 34                   (O) minor home modifications; and
- 35                   (P) adaptive aids;

36           (4) the following long-term services and  
37 supports under a Medicaid waiver program:

- 38                   (A) enhanced behavioral health  
39 services;
- 40                   (B) behavioral supports;
- 41                   (C) day habilitation; and
- 42                   (D) community support  
43 transportation;

44           (5) the following additional long-term  
45 services and supports:

- 46                   (A) housing supports;
- 47                   (B) behavioral health crisis  
48 intervention services; and
- 49                   (C) high medical needs services;

50           (6) other nonresidential long-term  
51 services and supports that the commission, in  
52 consultation and collaboration with the advisory  
53 committee and pilot program workgroup, determines are  
54 appropriate and consistent with applicable  
55 requirements governing the Medicaid waiver programs,  
56 person-centered approaches, home and community-based  
57 setting requirements, and achieving the most  
58 integrated and least restrictive setting based on an  
59 individual's needs and preferences; and

60           (7) dental services benefits in accordance  
61 with Subsection (a-1).

62           (a-1) In developing the pilot program, the  
63 commission shall:

64           (1) evaluate dental services benefits  
65 provided through Medicaid waiver programs and dental  
66 services benefits provided as a value-added service

1 under the Medicaid managed care delivery model;  
2 (2) determine which dental services  
3 benefits are the most cost-effective in reducing  
4 emergency room and inpatient hospital admissions due  
5 to poor oral health; and  
6 (3) based on the determination made under  
7 Subdivision (2), provide the most cost-effective  
8 dental services benefits to pilot program  
9 participants.

10 (f) Before implementing the pilot program, the  
11 commission, in consultation and collaboration with the  
12 advisory committee and pilot program workgroup, shall:

13 (1) for purposes of the pilot program  
14 only, develop recommendations to modify adult foster  
15 care and supported employment and employment  
16 assistance benefits to increase access to and  
17 availability of those services; and

18 (2) as necessary, define services listed  
19 under Subsections (a)(4) and (5) and any other  
20 services determined to be appropriate under Subsection  
21 (a)(6).

22 Revisor's Note

23 Section 534.1045(a), Government Code, provides  
24 that "[s]ubject to Subsection (b)" of Section  
25 534.1045, Government Code, the Health and Human  
26 Services Commission shall ensure that a managed care  
27 organization provides certain benefits and services  
28 under the pilot program implemented under Subchapter  
29 C, Chapter 534, Government Code, which is revised in  
30 this subchapter. The revised law omits the quoted  
31 language because the provisions of Subsection (b),  
32 revised in this chapter as Section 542.0110(c), apply  
33 by their own terms, and an additional statement to that  
34 effect is unnecessary.

35 Revised Law

36 Sec. 542.0110. PROVIDER PARTICIPATION. (a) The pilot  
37 program must allow a comprehensive long-term services and supports  
38 provider for individuals with an intellectual or developmental  
39 disability or similar functional needs that contracts with the  
40 commission to provide Medicaid services before the date the pilot  
41 program is implemented to voluntarily participate in the pilot  
42 program. A provider's choice not to participate in the pilot  
43 program does not affect the provider's status as a significant  
44 traditional provider.

1 (b) For the duration of the pilot program, the commission  
2 shall ensure that comprehensive long-term services and supports  
3 providers are:

- 4 (1) considered significant traditional providers; and
- 5 (2) included in the provider network of a managed care  
6 organization participating in the pilot program.

7 (c) A comprehensive long-term services and supports  
8 provider may deliver services listed under the following provisions  
9 only if the provider also delivers the services under a Medicaid  
10 waiver program:

- 11 (1) Sections 542.0109(a)(2)(A) and (D);
- 12 (2) Sections 542.0109(a)(3)(B), (C), (D), (G), (H),  
13 (J), (K), (L), and (M); and
- 14 (3) Section 542.0109(a)(4).

15 (d) A comprehensive long-term services and supports  
16 provider may deliver services listed under Sections 542.0109(a)(5)  
17 and (6) only if the managed care organization in the network of  
18 which the provider participates agrees, in a contract with the  
19 provider, to the provision of those services.

20 (e) Day habilitation services listed under Section  
21 542.0109(a)(4)(C) may be delivered by a provider who contracts or  
22 subcontracts with the commission to provide day habilitation  
23 services under the home and community-based services (HCS) waiver  
24 program or the ICF-IID program. (Gov. Code, Secs. 534.104(g),  
25 534.1045(b), (c), (d), 534.107(b).)

26 Source Law

27 [Sec. 534.104]

28 (g) The pilot program must allow a comprehensive  
29 long-term services and supports provider for  
30 individuals with an intellectual or developmental  
31 disability or similar functional needs that contracts  
32 with the commission to provide services under Medicaid  
33 before the implementation date of the pilot program to  
34 voluntarily participate in the pilot program. A  
35 provider's choice not to participate in the pilot  
36 program does not affect the provider's status as a  
37 significant traditional provider.

38 [Sec. 534.1045]

39 (b) A comprehensive long-term services and  
40 supports provider may deliver services listed under

1 the following provisions only if the provider also  
2 delivers the services under a Medicaid waiver program:

- 3 (1) Subsections (a)(2)(A) and (D);
- 4 (2) Subsections (a)(3)(B), (C), (D), (G),  
5 (H), (J), (K), (L), and (M); and
- 6 (3) Subsection (a)(4).

7 (c) A comprehensive long-term services and  
8 supports provider may deliver services listed under  
9 Subsections (a)(5) and (6) only if the managed care  
10 organization in the network of which the provider  
11 participates agrees to, in a contract with the  
12 provider, the provision of those services.

13 (d) Day habilitation services listed under  
14 Subsection (a)(4)(C) may be delivered by a provider  
15 who contracts or subcontracts with the commission to  
16 provide day habilitation services under the home and  
17 community-based services (HCS) waiver program or the  
18 ICF-IID program.

19 [Sec. 534.107]

20 (b) For the duration of the pilot program, the  
21 commission shall ensure that comprehensive long-term  
22 services and supports providers are considered  
23 significant traditional providers and included in the  
24 provider network of a managed care organization  
25 participating in the pilot program.

26 Revised Law

27 Sec. 542.0111. CARE COORDINATION. (a) A comprehensive  
28 long-term services and supports provider participating in the pilot  
29 program shall work in coordination with the care coordinators of a  
30 managed care organization participating in the pilot program to  
31 ensure the seamless daily delivery of acute care and long-term  
32 services and supports in accordance with a pilot program  
33 participant's plan of care.

34 (b) A managed care organization may reimburse a  
35 comprehensive long-term services and supports provider for  
36 coordinating with care coordinators under this section. (Gov.  
37 Code, Sec. 534.1045(e).)

38 Source Law

39 (e) A comprehensive long-term services and  
40 supports provider participating in the pilot program  
41 shall work in coordination with the care coordinators  
42 of a managed care organization participating in the  
43 pilot program to ensure the seamless delivery of acute  
44 care and long-term services and supports on a daily  
45 basis in accordance with an individual's plan of care.  
46 A comprehensive long-term services and supports  
47 provider may be reimbursed by a managed care  
48 organization for coordinating with care coordinators  
49 under this subsection.

50 Revised Law

51 Sec. 542.0112. PERSON-CENTERED PLANNING. The commission,

1 in collaboration with the advisory committee and pilot program work  
2 group, shall ensure that each pilot program participant or the  
3 participant's legally authorized representative has access to a  
4 comprehensive, facilitated, person-centered plan that identifies  
5 outcomes for the participant and drives the development of the  
6 individualized budget. The consumer direction model must be an  
7 available option for a participant to achieve self-determination,  
8 choice, and control. (Gov. Code, Sec. 534.109.)

9 Source Law

10 Sec. 534.109. PERSON-CENTERED PLANNING. The  
11 commission, in consultation and collaboration with the  
12 advisory committee and pilot program workgroup, shall  
13 ensure that each individual who receives services and  
14 supports under Medicaid through the pilot program, or  
15 the individual's legally authorized representative,  
16 has access to a comprehensive, facilitated,  
17 person-centered plan that identifies outcomes for the  
18 individual and drives the development of the  
19 individualized budget. The consumer direction model  
20 must be an available option for individuals to achieve  
21 self-determination, choice, and control.

22 Revised Law

23 Sec. 542.0113. USE OF INNOVATIVE TECHNOLOGY. A pilot  
24 program participant is not required to use an innovative technology  
25 described by Section 542.0102(c)(9). If a participant chooses to  
26 use an innovative technology described by that subdivision, the  
27 commission shall ensure that:

28 (1) services associated with the technology are  
29 delivered in a manner that:

30 (A) ensures the participant's privacy, health,  
31 and well-being;

32 (B) provides access to housing in the most  
33 integrated and least restrictive environment;

34 (C) assesses individual needs and preferences to  
35 promote autonomy, self-determination, the use of the consumer  
36 direction model, and privacy;

37 (D) increases personal independence;

38 (E) specifies the extent to which the innovative  
39 technology will be used, including:

1 (i) the times of day during which the  
2 technology will be used;

3 (ii) the place in which the technology is  
4 authorized to be used;

5 (iii) the types of telemonitoring or remote  
6 monitoring that will be used; and

7 (iv) the purposes for which the technology  
8 will be used; and

9 (F) is consistent with and agreed on during the  
10 person-centered planning process;

11 (2) staff overseeing the use of the innovative  
12 technology:

13 (A) review the person-centered and  
14 implementation plans for each participant before overseeing the use  
15 of the innovative technology; and

16 (B) demonstrate competency regarding the support  
17 needs of each participant using the innovative technology;

18 (3) a participant using the innovative technology is  
19 able to request the removal of equipment associated with the  
20 technology and, on receipt of a request for the removal, the  
21 equipment is immediately removed; and

22 (4) a participant is not required to use telemedicine  
23 at any point during the pilot program and, if the participant  
24 refuses to use telemedicine, the managed care organization  
25 providing pilot program health care services to the participant  
26 arranges for services that do not include telemedicine. (Gov.  
27 Code, Sec. 534.104(b).)

28 Source Law

29 (b) An individual is not required to use an  
30 innovative technology described by Subsection  
31 (a)(10). If an individual chooses to use an innovative  
32 technology described by that subdivision, the  
33 commission shall ensure that services associated with  
34 the technology are delivered in a manner that:

35 (1) ensures the individual's privacy,  
36 health, and well-being;

37 (2) provides access to housing in the most  
38 integrated and least restrictive environment;

39 (3) assesses individual needs and

1 preferences to promote autonomy, self-determination,  
2 the use of the consumer direction model, and privacy;  
3 (4) increases personal independence;  
4 (5) specifies the extent to which the  
5 innovative technology will be used, including:  
6 (A) the times of day during which the  
7 technology will be used;  
8 (B) the place in which the technology  
9 may be used;  
10 (C) the types of telemonitoring or  
11 remote monitoring that will be used; and  
12 (D) for what purposes the technology  
13 will be used;  
14 (6) is consistent with and agreed on  
15 during the person-centered planning process;  
16 (7) ensures that staff overseeing the use  
17 of an innovative technology:  
18 (A) review the person-centered and  
19 implementation plans for each individual before  
20 overseeing the use of the innovative technology; and  
21 (B) demonstrate competency regarding  
22 the support needs of each individual using the  
23 innovative technology;  
24 (8) ensures that an individual using an  
25 innovative technology is able to request the removal  
26 of equipment relating to the technology and, on  
27 receipt of a request for the removal, the equipment is  
28 immediately removed; and  
29 (9) ensures that an individual is not  
30 required to use telemedicine at any point during the  
31 pilot program and, in the event the individual refuses  
32 to use telemedicine, the managed care organization  
33 providing health care services to the individual under  
34 the pilot program arranges for services that do not  
35 include telemedicine.

36 Revised Law

37 Sec. 542.0114. INFORMATIONAL MATERIALS. (a) To ensure  
38 that prospective pilot program participants are able to make an  
39 informed decision on whether to participate in the pilot program,  
40 the commission, in collaboration with the advisory committee and  
41 pilot program work group, shall develop and distribute  
42 informational materials that describe the pilot program's benefits  
43 and impact on current services and other related information.

44 (b) The commission shall establish a timeline and process  
45 for developing and distributing the informational materials and  
46 ensure that:

47 (1) the materials are developed and distributed to  
48 individuals eligible to participate in the pilot program with  
49 sufficient time to educate the individuals, their families, and  
50 other persons actively involved in their lives regarding the pilot  
51 program;



1 program;  
2 (2) individuals eligible to participate in  
3 the pilot program, including individuals enrolled in  
4 the STAR+PLUS Medicaid managed care program, their  
5 families, and other persons actively involved in their  
6 lives, receive the materials and oral information on  
7 the pilot program;

8 (3) the materials contain clear, simple  
9 language presented in a manner that is easy to  
10 understand; and

11 (4) the materials explain, at a minimum,  
12 that:

13 (A) on conclusion of the pilot  
14 program, pilot program participants will be asked to  
15 provide feedback on their experience, including  
16 feedback on whether the pilot program was able to meet  
17 their unique support needs;

18 (B) participation in the pilot  
19 program does not remove individuals from any Medicaid  
20 waiver program interest list;

21 (C) individuals who choose to  
22 participate in the pilot program and who, during the  
23 pilot program's operation, are offered enrollment in a  
24 Medicaid waiver program may accept the enrollment,  
25 transition, or diversion offer; and

26 (D) pilot program participants have a  
27 choice among acute care and comprehensive long-term  
28 services and supports providers and service delivery  
29 options, including the consumer direction model and  
30 comprehensive services model.

31 Revised Law

32 Sec. 542.0115. IMPLEMENTATION, LOCATION, AND DURATION. The  
33 commission shall:

34 (1) implement the pilot program on September 1, 2023;

35 (2) conduct the pilot program in a STAR+PLUS Medicaid  
36 managed care service area the commission selects; and

37 (3) operate the pilot program for at least 24 months.

38 (Gov. Code, Sec. 534.106.)

39 Source Law

40 Sec. 534.106. IMPLEMENTATION, LOCATION, AND  
41 DURATION. (a) The commission shall implement the  
42 pilot program on September 1, 2023.

43 (b) The pilot program shall operate for at least  
44 24 months.

45 (c) The pilot program shall be conducted in a  
46 STAR+PLUS Medicaid managed care service area selected  
47 by the commission.

48 Revised Law

49 Sec. 542.0116. RECIPIENT ENROLLMENT, PARTICIPATION, AND  
50 ELIGIBILITY. (a) The commission, in collaboration with the

51 advisory committee and pilot program work group, shall develop  
52 pilot program participant eligibility criteria. The criteria must

1 ensure that pilot program participants:

2 (1) include individuals with an intellectual or  
3 developmental disability or a cognitive disability, including:

4 (A) individuals with autism;

5 (B) individuals with significant complex  
6 behavioral, medical, and physical needs who are receiving home and  
7 community-based services through the STAR+PLUS Medicaid managed  
8 care program;

9 (C) individuals enrolled in the STAR+PLUS  
10 Medicaid managed care program who:

11 (i) are on a Medicaid waiver program  
12 interest list;

13 (ii) meet the criteria for an intellectual  
14 or developmental disability; or

15 (iii) have a traumatic brain injury that  
16 occurred after the age of 21; and

17 (D) other individuals with disabilities who have  
18 similar functional needs without regard to the age of onset or  
19 diagnosis; and

20 (2) do not include individuals who are receiving only  
21 acute care services under the STAR+PLUS Medicaid managed care  
22 program and are enrolled in the community-based ICF-IID program or  
23 another Medicaid waiver program.

24 (b) An individual who is eligible to participate in the  
25 pilot program will be enrolled automatically. The decision to opt  
26 out of participating may be made only by the individual or the  
27 individual's legally authorized representative.

28 (c) Before implementing the pilot program, the commission,  
29 in collaboration with the advisory committee and pilot program work  
30 group, shall develop and implement a process to ensure that pilot  
31 program participants remain eligible for Medicaid for 12  
32 consecutive months during the pilot program. (Gov. Code, Secs.  
33 534.104(k), 534.1065(a), (c).)

1 Source Law

2 [Sec. 534.104]

3 (k) Before implementing the pilot program, the  
4 commission, in consultation and collaboration with the  
5 advisory committee and pilot program workgroup, shall  
6 develop and implement a process to ensure pilot  
7 program participants remain eligible for Medicaid  
8 benefits for 12 consecutive months during the pilot  
9 program.

10 Sec. 534.1065. RECIPIENT ENROLLMENT,  
11 PARTICIPATION, AND ELIGIBILITY. (a) An individual  
12 who is eligible for the pilot program will be enrolled  
13 automatically, and the decision whether to opt out of  
14 participation in the pilot program and not receive  
15 long-term services and supports under the pilot  
16 program may be made only by the individual or the  
17 individual's legally authorized representative.

18 (c) The commission, in consultation and  
19 collaboration with the advisory committee and pilot  
20 program workgroup, shall develop pilot program  
21 participant eligibility criteria. The criteria must  
22 ensure pilot program participants:

23 (1) include individuals with an  
24 intellectual or developmental disability or a  
25 cognitive disability, including:

26 (A) individuals with autism;

27 (B) individuals with significant  
28 complex behavioral, medical, and physical needs who  
29 are receiving home and community-based services  
30 through the STAR+PLUS Medicaid managed care program;

31 (C) individuals enrolled in the  
32 STAR+PLUS Medicaid managed care program who:

33 (i) are on a Medicaid waiver  
34 program interest list;

35 (ii) meet the criteria for an  
36 intellectual or developmental disability; or

37 (iii) have a traumatic brain  
38 injury that occurred after the age of 21; and

39 (D) other individuals with  
40 disabilities who have similar functional needs without  
41 regard to the age of onset or diagnosis; and

42 (2) do not include individuals who are  
43 receiving only acute care services under the STAR+PLUS  
44 Medicaid managed care program and are enrolled in the  
45 community-based ICF-IID program or another Medicaid  
46 waiver program.

47 Revised Law

48 Sec. 542.0117. PILOT PROGRAM INFORMATION COLLECTION AND  
49 ANALYSIS. (a) The commission, in collaboration with the advisory  
50 committee and pilot program work group, shall determine the  
51 information to collect from a managed care organization  
52 participating in the pilot program for use in conducting the  
53 evaluation and preparing the report under Section 542.0119.

54 (b) For the duration of the pilot program, a managed care  
55 organization participating in the pilot program shall submit to the

1 commission and the advisory committee quarterly reports on the  
2 services provided to each pilot program participant. The reports  
3 must include information on:

4 (1) the level of each requested service and the  
5 authorization and utilization rates for those services;

6 (2) timelines of:

7 (A) the authorization of each requested service;

8 (B) the initiation of each requested service;

9 (C) the delivery of each requested service; and

10 (D) each unplanned break in the delivery of  
11 requested services and the duration of the break;

12 (3) the number of pilot program participants using  
13 employment assistance and supported employment services;

14 (4) the number of service denials and fair hearings  
15 and the dispositions of the fair hearings;

16 (5) the number of complaints and inquiries the managed  
17 care organization received and the outcome of each complaint; and

18 (6) the number of pilot program participants who  
19 choose the consumer direction model and the reasons other  
20 participants did not choose the consumer direction model.

21 (c) The commission shall ensure that the mechanisms to  
22 report and track the information and data required by Subsections  
23 (a) and (b) are established before implementing the pilot program.

24 (d) For purposes of making a recommendation about a system  
25 of programs and services for implementation through future state  
26 legislation or rules, the commission, in collaboration with the  
27 advisory committee and pilot program work group, shall analyze:

28 (1) information provided by managed care  
29 organizations participating in the pilot program; and

30 (2) any information the commission collects during the  
31 operation of the pilot program.

32 (e) The analysis under Subsection (d) must include an  
33 assessment of the effect of the managed care strategies implemented  
34 in the pilot program on the goals described by Sections 542.0102(b)

1 and (c), 542.0103, 542.0110(a), 542.0113, and 542.0116(c). (Gov.  
2 Code, Secs. 534.104(i), (j), 534.108.)

3 Source Law

4 [Sec. 534.104]

5 (i) The commission, in consultation and  
6 collaboration with the advisory committee and pilot  
7 program workgroup, shall analyze information provided  
8 by the managed care organizations participating in the  
9 pilot program and any information collected by the  
10 commission during the operation of the pilot program  
11 for purposes of making a recommendation about a system  
12 of programs and services for implementation through  
13 future state legislation or rules.

14 (j) The analysis under Subsection (i) must  
15 include an assessment of the effect of the managed care  
16 strategies implemented in the pilot program on the  
17 goals described by this section.

18 Sec. 534.108. PILOT PROGRAM INFORMATION. (a)  
19 The commission, in consultation and collaboration with  
20 the advisory committee and pilot program workgroup,  
21 shall determine which information will be collected  
22 from a managed care organization participating in the  
23 pilot program to use in conducting the evaluation and  
24 preparing the report under Section 534.112.

25 (b) For the duration of the pilot program, a  
26 managed care organization participating in the pilot  
27 program shall submit to the commission and the  
28 advisory committee quarterly reports on the services  
29 provided to each pilot program participant that  
30 include information on:

31 (1) the level of each requested service  
32 and the authorization and utilization rates for those  
33 services;

34 (2) timelines of:

35 (A) the delivery of each requested  
36 service;

37 (B) authorization of each requested  
38 service;

39 (C) the initiation of each requested  
40 service; and

41 (D) each unplanned break in the  
42 delivery of requested services and the duration of the  
43 break;

44 (3) the number of pilot program  
45 participants using employment assistance and  
46 supported employment services;

47 (4) the number of service denials and fair  
48 hearings and the dispositions of fair hearings;

49 (5) the number of complaints and inquiries  
50 received by the managed care organization and the  
51 outcome of each complaint; and

52 (6) the number of pilot program  
53 participants who choose the consumer direction model  
54 and the reasons why other participants did not choose  
55 the consumer direction model.

56 (c) The commission shall ensure that the  
57 mechanisms to report and track the information and  
58 data required by this section are established before  
59 implementing the pilot program.

60 Revisor's Note

61 Section 534.104(j), Government Code, refers to

1 goals described by "this section," meaning Section  
2 534.104, Government Code. The relevant provisions of  
3 Section 534.104 are revised in this chapter as  
4 Sections 542.0102(b) and (c), 542.0103, 542.0110(a),  
5 542.0113, and 542.0116(c). The revised law is drafted  
6 accordingly.

7 Revised Law

8 Sec. 542.0118. PILOT PROGRAM CONCLUSION; PUBLICATION OF  
9 CONTINUATION. On September 1, 2025, the pilot program is concluded  
10 unless the commission continues the pilot program under Section  
11 542.0120. If the commission continues the pilot program, the  
12 commission shall publish notice of that continuation in the Texas  
13 Register not later than September 1, 2025. (Gov. Code, Sec.  
14 534.111.)

15 Source Law

16 Sec. 534.111. CONCLUSION OF PILOT PROGRAM. (a)  
17 On September 1, 2025, the pilot program is concluded  
18 unless the commission continues the pilot program  
19 under Section 534.110.

20 (b) If the commission continues the pilot  
21 program under Section 534.110, the commission shall  
22 publish notice of the pilot program's continuance in  
23 the Texas Register not later than September 1, 2025.

24 Revised Law

25 Sec. 542.0119. EVALUATIONS AND REPORTS. (a) The  
26 commission, in collaboration with the advisory committee and pilot  
27 program work group, shall review and evaluate the progress and  
28 outcomes of the pilot program and submit, as part of the annual  
29 report required under Section 542.0054, a report on the pilot  
30 program's status that includes recommendations for improving the  
31 pilot program.

32 (b) Not later than September 1, 2026, the commission, in  
33 collaboration with the advisory committee and pilot program work  
34 group, shall prepare and submit to the legislature a written report  
35 that evaluates the pilot program based on a comprehensive analysis.  
36 The analysis must:

37 (1) assess the effect of the pilot program on:

1 (A) access to and quality of long-term services  
2 and supports;

3 (B) informed choice and meaningful outcomes  
4 using person-centered planning, flexible consumer-directed  
5 services, individualized budgeting, and self-determination,  
6 including a pilot program participant's inclusion in the community;

7 (C) the integration of service coordination of  
8 acute care services and long-term services and supports;

9 (D) employment assistance and customized,  
10 integrated, competitive employment options;

11 (E) the number, types, and dispositions of fair  
12 hearings and appeals in accordance with federal and state law;

13 (F) increasing the use and flexibility of the  
14 consumer direction model;

15 (G) increasing the use of alternatives to  
16 guardianship, including supported decision-making agreements as  
17 defined by Section 1357.002, Estates Code;

18 (H) achieving the best and most cost-effective  
19 funding use based on a pilot program participant's needs and  
20 preferences; and

21 (I) attendant recruitment and retention;

22 (2) analyze the experiences and outcomes of the  
23 following systems changes:

24 (A) the comprehensive assessment instrument  
25 described by Section 533A.0335, Health and Safety Code;

26 (B) the 21st Century Cures Act (Pub. L.  
27 No. 114-255);

28 (C) implementation of the federal rule adopted by  
29 the Centers for Medicare and Medicaid Services and published at 79  
30 Fed. Reg. 2948 (January 16, 2014) related to the provision of  
31 long-term services and supports through a home and community-based  
32 services (HCS) waiver program under Section 1915(c), 1915(i), or  
33 1915(k) of the Social Security Act (42 U.S.C. Section 1396n(c),  
34 (i), or (k));

1 (D) the provision of basic attendant and  
2 habilitation services under Section 542.0152; and

3 (E) the benefits of providing STAR+PLUS Medicaid  
4 managed care services to individuals based on functional needs;

5 (3) include feedback on the pilot program based on the  
6 personal experiences of:

7 (A) individuals with an intellectual or  
8 developmental disability and individuals with similar functional  
9 needs who were pilot program participants;

10 (B) families of and other persons actively  
11 involved in the lives of individuals described by Paragraph (A);  
12 and

13 (C) comprehensive long-term services and  
14 supports providers who delivered services under the pilot program;

15 (4) be incorporated in the annual report required  
16 under Section 542.0054; and

17 (5) include recommendations on:

18 (A) a system of programs and services for the  
19 legislature's consideration;

20 (B) necessary statutory changes; and

21 (C) whether to implement the pilot program  
22 statewide under the STAR+PLUS Medicaid managed care program for  
23 eligible individuals. (Gov. Code, Sec. 534.112.)

24 Source Law

25 Sec. 534.112. PILOT PROGRAM EVALUATIONS AND  
26 REPORTS. (a) The commission, in consultation and  
27 collaboration with the advisory committee and pilot  
28 program workgroup, shall review and evaluate the  
29 progress and outcomes of the pilot program and submit,  
30 as part of the annual report required under Section  
31 534.054, a report on the pilot program's status that  
32 includes recommendations for improving the program.

33 (b) Not later than September 1, 2026, the  
34 commission, in consultation and collaboration with the  
35 advisory committee and pilot program workgroup, shall  
36 prepare and submit to the legislature a written report  
37 that evaluates the pilot program based on a  
38 comprehensive analysis. The analysis must:

39 (1) assess the effect of the pilot program  
40 on:

41 (A) access to and quality of  
42 long-term services and supports;

43 (B) informed choice and meaningful

1 outcomes using person-centered planning, flexible  
2 consumer-directed services, individualized budgeting,  
3 and self-determination, including a pilot program  
4 participant's inclusion in the community;

5 (C) the integration of service  
6 coordination of acute care services and long-term  
7 services and supports;

8 (D) employment assistance and  
9 customized, integrated, competitive employment  
10 options;

11 (E) the number, types, and  
12 dispositions of fair hearings and appeals in  
13 accordance with applicable federal and state law;

14 (F) increasing the use and  
15 flexibility of the consumer direction model;

16 (G) increasing the use of  
17 alternatives to guardianship, including supported  
18 decision-making agreements as defined by Section  
19 1357.002, Estates Code;

20 (H) achieving the best and most  
21 cost-effective use of funding based on a pilot program  
22 participant's needs and preferences; and

23 (I) attendant recruitment and  
24 retention;

25 (2) analyze the experiences and outcomes  
26 of the following systems changes:

27 (A) the comprehensive assessment  
28 instrument described by Section 533A.0335, Health and  
29 Safety Code;

30 (B) the 21st Century Cures Act (Pub.  
31 L. No. 114-255);

32 (C) implementation of the federal  
33 rule adopted by the Centers for Medicare and Medicaid  
34 Services and published at 79 Fed. Reg. 2948 (January  
35 16, 2014) related to the provision of long-term  
36 services and supports through a home and  
37 community-based services (HCS) waiver program under  
38 Section 1915(c), 1915(i), or 1915(k) of the federal  
39 Social Security Act (42 U.S.C. Section 1396n(c), (i),  
40 or (k));

41 (D) the provision of basic attendant  
42 and habilitation services under Section 534.152; and

43 (E) the benefits of providing  
44 STAR+PLUS Medicaid managed care services to persons  
45 based on functional needs;

46 (3) include feedback on the pilot program  
47 based on the personal experiences of:

48 (A) individuals with an intellectual  
49 or developmental disability and individuals with  
50 similar functional needs who participated in the pilot  
51 program;

52 (B) families of and other persons  
53 actively involved in the lives of individuals  
54 described by Paragraph (A); and

55 (C) comprehensive long-term services  
56 and supports providers who delivered services under  
57 the pilot program;

58 (4) be incorporated in the annual report  
59 required under Section 534.054; and

60 (5) include recommendations on:

61 (A) a system of programs and services  
62 for consideration by the legislature;

63 (B) necessary statutory changes; and

64 (C) whether to implement the pilot  
65 program statewide under the STAR+PLUS Medicaid managed  
66 care program for eligible individuals.

1 Revised Law

2 Sec. 542.0120. TRANSITION BETWEEN PROGRAMS; CONTINUITY OF  
3 CARE. (a) During the evaluation of the pilot program required  
4 under Section 542.0119, the commission may continue the pilot  
5 program to ensure continuity of care for pilot program  
6 participants. If, following the evaluation, the commission does  
7 not continue the pilot program, the commission shall ensure that  
8 there is a comprehensive plan for transitioning the provision of  
9 Medicaid benefits for pilot program participants to the benefits  
10 provided before participation in the pilot program.

11 (b) A transition plan under Subsection (a) shall be  
12 developed in collaboration with the advisory committee and pilot  
13 program work group and with stakeholder input as described by  
14 Section 542.0105. (Gov. Code, Sec. 534.110.)

15 Source Law

16 Sec. 534.110. TRANSITION BETWEEN PROGRAMS;  
17 CONTINUITY OF SERVICES. (a) During the evaluation of  
18 the pilot program required under Section 534.112, the  
19 commission may continue the pilot program to ensure  
20 continuity of care for pilot program participants. If  
21 the commission does not continue the pilot program  
22 following the evaluation, the commission shall ensure  
23 that there is a comprehensive plan for transitioning  
24 the provision of Medicaid benefits for pilot program  
25 participants to the benefits provided before  
26 participating in the pilot program.

27 (b) A transition plan under Subsection (a) shall  
28 be developed in consultation and collaboration with  
29 the advisory committee and pilot program workgroup and  
30 with stakeholder input as described by Section  
31 534.103.

32 Revised Law

33 Sec. 542.0121. SERVICE TRANSITION REQUIREMENTS. (a) For  
34 purposes of implementing the pilot program and transitioning the  
35 provision of services provided to recipients under certain Medicaid  
36 waiver programs to a Medicaid managed care delivery model following  
37 completion of the pilot program, the commission shall:

38 (1) implement and maintain a certification process for  
39 and maintain regulatory oversight over providers under the Texas  
40 home living (TxHmL) and home and community-based services (HCS)  
41 waiver programs; and



1 and

2 (2) require managed care organizations to  
3 include in the organizations' provider networks  
4 providers who are certified in accordance with the  
5 certification process described by Subdivision (1).

6 (b) For purposes of implementing the pilot  
7 program under Subchapter C and transitioning the  
8 provision of services described by Section 534.202 to  
9 the STAR+PLUS Medicaid managed care program, a  
10 comprehensive long-term services and supports  
11 provider:

12 (1) must report to the managed care  
13 organization in the network of which the provider  
14 participates each encounter of any directly contracted  
15 service;

16 (2) must provide to the managed care  
17 organization quarterly reports on:

18 (A) coordinated services and time  
19 frames for the delivery of those services; and

20 (B) the goals and objectives outlined  
21 in an individual's person-centered plan and progress  
22 made toward meeting those goals and objectives; and

23 (3) may not be held accountable for the  
24 provision of services specified in an individual's  
25 service plan that are not authorized or subsequently  
26 denied by the managed care organization.

27 (c) On transitioning services under a Medicaid  
28 waiver program to a Medicaid managed care delivery  
29 model, the commission shall ensure that individuals do  
30 not lose benefits they receive under the Medicaid  
31 waiver program.

32 Revisor's Note

33 Section 534.252(b), Government Code, refers to  
34 "services described by Section 534.202," Government  
35 Code. The relevant provisions of Section 534.202 are  
36 revised in this chapter as Section 542.0201. The  
37 revised law is drafted accordingly.

38 SUBCHAPTER D. STAGE ONE: PROVISION OF ACUTE CARE AND CERTAIN OTHER  
39 SERVICES

40 Revised Law

41 Sec. 542.0151. DELIVERY OF ACUTE CARE SERVICES TO  
42 INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY. (a)  
43 Subject to Section \_\_\_\_\_ [[[Section 533.0025]]], the commission  
44 shall:

45 (1) provide acute care Medicaid benefits to  
46 individuals with an intellectual or developmental disability  
47 through the STAR+PLUS Medicaid managed care program or the most  
48 appropriate integrated capitated managed care program delivery  
49 model; and

1 (2) monitor the provision of those benefits.

2 (b) The commission, in collaboration with the advisory  
3 committee, shall analyze the outcomes of providing acute care  
4 Medicaid benefits to individuals with an intellectual or  
5 developmental disability under a model described by Subsection (a).  
6 The analysis must:

7 (1) include an assessment of the effects of the  
8 delivery model on:

9 (A) access to and quality of acute care services;  
10 and

11 (B) the number and types of fair hearing and  
12 appeals processes in accordance with federal law;

13 (2) be incorporated into the annual report to the  
14 legislature required under Section 542.0054; and

15 (3) include recommendations for delivery model  
16 improvements and implementation for the legislature's  
17 consideration, including recommendations for needed statutory  
18 changes. (Gov. Code, Sec. 534.151.)

19 Source Law

20 Sec. 534.151. DELIVERY OF ACUTE CARE SERVICES  
21 FOR INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL  
22 DISABILITY. (a) Subject to Section 533.0025, the  
23 commission shall provide acute care Medicaid benefits  
24 to individuals with an intellectual or developmental  
25 disability through the STAR + PLUS Medicaid managed  
26 care program or the most appropriate integrated  
27 capitated managed care program delivery model and  
28 monitor the provision of those benefits.

29 (b) The commission and the department, in  
30 consultation and collaboration with the advisory  
31 committee, shall analyze the outcomes of providing  
32 acute care Medicaid benefits to individuals with an  
33 intellectual or developmental disability under a model  
34 specified in Subsection (a). The analysis must:

35 (1) include an assessment of the effects  
36 on:

37 (A) access to and quality of acute  
38 care services; and

39 (B) the number and types of fair  
40 hearing and appeals processes in accordance with  
41 applicable federal law;

42 (2) be incorporated into the annual report  
43 to the legislature required under Section 534.054; and

44 (3) include recommendations for delivery  
45 model improvements and implementation for  
46 consideration by the legislature, including  
47 recommendations for needed statutory changes.

1 Revisor's Note

2 Section 534.151(b), Government Code, refers to  
3 the Health and Human Services Commission and "the  
4 department." Former Section 534.001(3), Government  
5 Code, defined "department" for purposes of the chapter  
6 from which this chapter of revised law is derived to  
7 mean the Department of Aging and Disability Services.  
8 That definition was repealed in 2019 by Chapter 1330  
9 (H.B. 4533), Acts of the 86th Legislature, Regular  
10 Session. The Department of Aging and Disability  
11 Services was abolished effective September 1, 2017, in  
12 accordance with Section 531.0202(b), Government Code,  
13 which is executed law that expires September 1, 2023,  
14 and the powers and duties of that department were  
15 transferred to the commission. Section 531.0011,  
16 Government Code, which is revised in this subtitle as  
17 Section \_\_\_\_\_, provides that a reference to the  
18 department means the commission or the appropriate  
19 division of the commission. Because the department no  
20 longer exists and the commission has assumed the  
21 powers and duties of the department, the revised law  
22 omits "department."

23 Revised Law

24 Sec. 542.0152. DELIVERY OF CERTAIN OTHER SERVICES UNDER  
25 STAR+PLUS MEDICAID MANAGED CARE PROGRAM AND BY WAIVER PROGRAM  
26 PROVIDERS. (a) The commission shall:

27 (1) implement the option for the delivery of basic  
28 attendant and habilitation services to individuals with an  
29 intellectual or developmental disability under the STAR+PLUS  
30 Medicaid managed care program that:

31 (A) is the most cost-effective; and

32 (B) maximizes federal funding for the delivery of  
33 services for that program and other similar programs; and

34 (2) provide voluntary training to individuals

1 receiving services under the STAR+PLUS Medicaid managed care  
2 program or their legally authorized representatives regarding how  
3 to select, manage, and dismiss a personal attendant providing basic  
4 attendant and habilitation services under the program.

5 (b) The commission shall require each managed care  
6 organization that contracts with the commission to provide basic  
7 attendant and habilitation services under the STAR+PLUS Medicaid  
8 managed care program in accordance with this section to:

9 (1) include in the organization's provider network for  
10 the provision of those services:

11 (A) home and community support services agencies  
12 licensed under Chapter 142, Health and Safety Code, with which the  
13 commission has a contract to provide services under the community  
14 living assistance and support services (CLASS) waiver program; and

15 (B) persons exempted from licensing under  
16 Section 142.003(a)(19), Health and Safety Code, with which the  
17 commission has a contract to provide services under:

18 (i) the home and community-based services  
19 (HCS) waiver program; or

20 (ii) the Texas home living (TxHmL) waiver  
21 program;

22 (2) review and consider any assessment conducted by a  
23 local intellectual and developmental disability authority  
24 providing intellectual and developmental disability service  
25 coordination under Subsection (c); and

26 (3) enter into a written agreement with each local  
27 intellectual and developmental disability authority in the service  
28 area regarding the processes the organization and the authority  
29 will use to coordinate the services provided to individuals with an  
30 intellectual or developmental disability.

31 (c) The commission shall contract with and make contract  
32 payments to local intellectual and developmental disability  
33 authorities to:

34 (1) provide intellectual and developmental disability

1 service coordination to individuals with an intellectual or  
2 developmental disability under the STAR+PLUS Medicaid managed care  
3 program by assisting individuals who are eligible to receive  
4 services in a community-based setting, including individuals  
5 transitioning to a community-based setting;

6 (2) provide to the appropriate managed care  
7 organization, based on the functional need, risk factors, and  
8 desired outcomes of an individual with an intellectual or  
9 developmental disability, an assessment of whether the individual  
10 needs attendant or habilitation services;

11 (3) assist individuals with an intellectual or  
12 developmental disability with developing the individuals' plans of  
13 care under the STAR+PLUS Medicaid managed care program, including  
14 with making any changes resulting from periodic reassessments of  
15 the plans;

16 (4) provide to the appropriate managed care  
17 organization and the commission information regarding the  
18 recommended plans of care with which the authorities provide  
19 assistance as provided by Subdivision (3), including documentation  
20 necessary to demonstrate the need for care described by a plan; and

21 (5) annually provide to the appropriate managed care  
22 organization and the commission a description of outcomes based on  
23 an individual's plan of care.

24 (d) Local intellectual and developmental disability  
25 authorities providing service coordination under this section may  
26 not also provide attendant and habilitation services under this  
27 section.

28 (e) A local intellectual and developmental disability  
29 authority with which the commission contracts under Subsection (c)  
30 may subcontract with an eligible person, including a nonprofit  
31 entity, to coordinate the delivery of services to individuals with  
32 an intellectual or developmental disability under this section.  
33 The executive commissioner by rule shall establish minimum  
34 qualifications a person must meet to be considered an eligible

1 person under this subsection.

2 (f) The commission may contract with providers  
3 participating in the home and community-based services (HCS) waiver  
4 program, the Texas home living (TxHmL) waiver program, the  
5 community living assistance and support services (CLASS) waiver  
6 program, or the deaf-blind with multiple disabilities (DBMD) waiver  
7 program for the delivery of basic attendant and habilitation  
8 services to individuals as described by Subsection (a). The  
9 commission has regulatory and oversight authority over the  
10 providers with which the commission contracts for the delivery of  
11 those services. (Gov. Code, Secs. 534.152(a), (b), (c), (d), (f),  
12 (g).)

13 Source Law

14 Sec. 534.152. DELIVERY OF CERTAIN OTHER  
15 SERVICES UNDER STAR + PLUS MEDICAID MANAGED CARE  
16 PROGRAM AND BY WAIVER PROGRAM PROVIDERS. (a) The  
17 commission shall:

18 (1) implement the most cost-effective  
19 option for the delivery of basic attendant and  
20 habilitation services for individuals with an  
21 intellectual or developmental disability under the  
22 STAR + PLUS Medicaid managed care program that  
23 maximizes federal funding for the delivery of services  
24 for that program and other similar programs; and

25 (2) provide voluntary training to  
26 individuals receiving services under the STAR + PLUS  
27 Medicaid managed care program or their legally  
28 authorized representatives regarding how to select,  
29 manage, and dismiss personal attendants providing  
30 basic attendant and habilitation services under the  
31 program.

32 (b) The commission shall require that each  
33 managed care organization that contracts with the  
34 commission for the provision of basic attendant and  
35 habilitation services under the STAR + PLUS Medicaid  
36 managed care program in accordance with this section:

37 (1) include in the organization's provider  
38 network for the provision of those services:

39 (A) home and community support  
40 services agencies licensed under Chapter 142, Health  
41 and Safety Code, with which the department has a  
42 contract to provide services under the community  
43 living assistance and support services (CLASS) waiver  
44 program; and

45 (B) persons exempted from licensing  
46 under Section 142.003(a)(19), Health and Safety Code,  
47 with which the department has a contract to provide  
48 services under:

49 (i) the home and  
50 community-based services (HCS) waiver program; or

51 (ii) the Texas home living  
52 (TxHmL) waiver program;

53 (2) review and consider any assessment  
54 conducted by a local intellectual and developmental

1 disability authority providing intellectual and  
2 developmental disability service coordination under  
3 Subsection (c); and

4 (3) enter into a written agreement with  
5 each local intellectual and developmental disability  
6 authority in the service area regarding the processes  
7 the organization and the authority will use to  
8 coordinate the services of individuals with an  
9 intellectual or developmental disability.

10 (c) The department shall contract with and make  
11 contract payments to local intellectual and  
12 developmental disability authorities to conduct the  
13 following activities under this section:

14 (1) provide intellectual and  
15 developmental disability service coordination to  
16 individuals with an intellectual or developmental  
17 disability under the STAR + PLUS Medicaid managed care  
18 program by assisting those individuals who are  
19 eligible to receive services in a community-based  
20 setting, including individuals transitioning to a  
21 community-based setting;

22 (2) provide an assessment to the  
23 appropriate managed care organization regarding  
24 whether an individual with an intellectual or  
25 developmental disability needs attendant or  
26 habilitation services, based on the individual's  
27 functional need, risk factors, and desired outcomes;

28 (3) assist individuals with an  
29 intellectual or developmental disability with  
30 developing the individuals' plans of care under the  
31 STAR + PLUS Medicaid managed care program, including  
32 with making any changes resulting from periodic  
33 reassessments of the plans;

34 (4) provide to the appropriate managed  
35 care organization and the department information  
36 regarding the recommended plans of care with which the  
37 authorities provide assistance as provided by  
38 Subdivision (3), including documentation necessary to  
39 demonstrate the need for care described by a plan; and

40 (5) on an annual basis, provide to the  
41 appropriate managed care organization and the  
42 department a description of outcomes based on an  
43 individual's plan of care.

44 (d) Local intellectual and developmental  
45 disability authorities providing service coordination  
46 under this section may not also provide attendant and  
47 habilitation services under this section.

48 (f) A local intellectual and developmental  
49 disability authority with which the department  
50 contracts under Subsection (c) may subcontract with an  
51 eligible person, including a nonprofit entity, to  
52 coordinate the services of individuals with an  
53 intellectual or developmental disability under this  
54 section. The executive commissioner by rule shall  
55 establish minimum qualifications a person must meet to  
56 be considered an "eligible person" under this  
57 subsection.

58 (g) The department may contract with providers  
59 participating in the home and community-based services  
60 (HCS) waiver program, the Texas home living (TxHmL)  
61 waiver program, the community living assistance and  
62 support services (CLASS) waiver program, or the  
63 deaf-blind with multiple disabilities (DBMD) waiver  
64 program for the delivery of basic attendant and  
65 habilitation services described in Subsection (a) for  
66 individuals to which that subsection applies. The  
67 department has regulatory and oversight authority over

1 the providers with which the department contracts for  
2 the delivery of those services.

3 Revisor's Note

4 (1) Sections 534.152(b), (c), (f), and (g),  
5 Government Code, refer to "the department," meaning  
6 the Department of Aging and Disability Services as  
7 explained in the revisor's note to Section 542.0151 of  
8 this chapter. The revised law substitutes  
9 "commission" for "department" for the reason stated in  
10 that revisor's note.

11 (2) Section 534.152(e), Government Code,  
12 requires that certain service providers be considered  
13 significant traditional providers during the first  
14 three years that basic attendant and habilitation  
15 services are provided to certain individuals under the  
16 STAR+PLUS Medicaid managed care program. The Health  
17 and Human Services Commission began providing the  
18 services through that program in 2015. Therefore, the  
19 revised law omits that provision as executed. The  
20 omitted law reads:

21 (e) During the first three years  
22 basic attendant and habilitation services  
23 are provided to individuals with an  
24 intellectual or developmental disability  
25 under the STAR + PLUS Medicaid managed care  
26 program in accordance with this section,  
27 providers eligible to participate in the  
28 home and community-based services (HCS)  
29 waiver program, the Texas home living  
30 (TxHmL) waiver program, or the community  
31 living assistance and support services  
32 (CLASS) waiver program on September 1,  
33 2013, are considered significant  
34 traditional providers.

35 SUBCHAPTER E. STAGE TWO: TRANSITION OF ICF-IID PROGRAM RECIPIENTS  
36 AND LONG-TERM CARE MEDICAID WAIVER PROGRAM RECIPIENTS TO INTEGRATED  
37 MANAGED CARE SYSTEM

38 Revised Law

39 Sec. 542.0201. TRANSITION OF ICF-IID PROGRAM RECIPIENTS AND  
40 CERTAIN OTHER MEDICAID WAIVER PROGRAM RECIPIENTS TO MANAGED CARE  
41 PROGRAM. (a) This section applies to individuals with an

1 intellectual or developmental disability who are receiving  
2 long-term services and supports under:

- 3 (1) a Medicaid waiver program; or
- 4 (2) an ICF-IID program.

5 (b) After implementing the pilot program under Subchapter C  
6 and completing the evaluations required by Section 542.0119, the  
7 commission, in collaboration with the advisory committee, shall  
8 develop a plan for transitioning all or a portion of the services  
9 provided through a Medicaid waiver program or an ICF-IID program to  
10 a Medicaid managed care model. The plan must include:

11 (1) a process for transitioning the services in the  
12 following phases:

13 (A) beginning September 1, 2027, the Texas home  
14 living (TxHmL) waiver program services;

15 (B) beginning September 1, 2029, the community  
16 living assistance and support services (CLASS) waiver program  
17 services;

18 (C) beginning September 1, 2031, nonresidential  
19 services provided under the home and community-based services (HCS)  
20 waiver program and the deaf-blind with multiple disabilities (DBMD)  
21 waiver program; and

22 (D) subject to Subdivision (2), the residential  
23 services provided under an ICF-IID program, the home and  
24 community-based services (HCS) waiver program, and the deaf-blind  
25 with multiple disabilities (DBMD) waiver program; and

26 (2) a process for evaluating and determining the  
27 feasibility and cost efficiency of transitioning residential  
28 services described by Subdivision (1)(D) to a Medicaid managed care  
29 model based on an evaluation of a separate pilot program the  
30 commission, in collaboration with the advisory committee, conducts  
31 that operates after the transition process described by Subdivision  
32 (1).

33 (c) Before implementing the transition plan, the commission  
34 shall determine whether to:

1           (1) continue operating the Medicaid waiver programs or  
2 ICF-IID program only for purposes of providing, if applicable:

3           (A) supplemental long-term services and supports  
4 not available under the managed care program delivery model the  
5 commission selects; or

6           (B) long-term services and supports to Medicaid  
7 waiver program recipients who choose to continue receiving benefits  
8 under the waiver programs as provided by Section 542.0202(a); or

9           (2) provide all or a portion of the long-term services  
10 and supports previously available under the Medicaid waiver  
11 programs or ICF-IID program through the managed care program  
12 delivery model the commission selects.

13          (d) In implementing the transition plan, the commission  
14 shall develop a process to receive and evaluate input from  
15 interested statewide stakeholders that is in addition to the input  
16 the advisory committee provides.

17          (e) The commission shall ensure that there is a  
18 comprehensive plan for transitioning the provision of Medicaid  
19 benefits under this section that protects the continuity of care  
20 provided to individuals to whom this section applies and ensures  
21 that individuals have a choice among acute care and comprehensive  
22 long-term services and supports providers and service delivery  
23 options, including the consumer direction model.

24          (f) Before transitioning the provision of Medicaid benefits  
25 for children under this section, a managed care organization  
26 providing services under the managed care program delivery model  
27 the commission selects must demonstrate to the commission's  
28 satisfaction that the providers in the organization's provider  
29 network have experience and expertise in providing services to  
30 children with an intellectual or developmental disability.

31          (g) Before transitioning the provision of Medicaid benefits  
32 for adults under this section, a managed care organization  
33 providing services under the managed care program delivery model  
34 the commission selects must demonstrate to the commission's

1 satisfaction that the providers in the organization's provider  
2 network have experience and expertise in providing services to  
3 adults with an intellectual or developmental disability. (Gov.  
4 Code, Secs. 534.202(a), (b), (c), (d), (e), (f).)

5 Source Law

6 Sec. 534.202. DETERMINATION TO TRANSITION  
7 ICF-IID PROGRAM RECIPIENTS AND CERTAIN OTHER MEDICAID  
8 WAIVER PROGRAM RECIPIENTS TO MANAGED CARE PROGRAM.

9 (a) This section applies to individuals with an  
10 intellectual or developmental disability who are  
11 receiving long-term services and supports under:

- 12 (1) a Medicaid waiver program; or  
13 (2) an ICF-IID program.

14 (b) Subject to Subsection (g), after  
15 implementing the pilot program under Subchapter C and  
16 completing the evaluation under Section 534.112, the  
17 commission, in consultation and collaboration with the  
18 advisory committee, shall develop a plan for the  
19 transition of all or a portion of the services provided  
20 through an ICF-IID program or a Medicaid waiver  
21 program to a Medicaid managed care model. The plan  
22 must include:

23 (1) a process for transitioning the  
24 services in phases as follows:

25 (A) beginning September 1, 2027, the  
26 Texas home living (TxHmL) waiver program services;

27 (B) beginning September 1, 2029, the  
28 community living assistance and support services  
29 (CLASS) waiver program services;

30 (C) beginning September 1, 2031,  
31 nonresidential services provided under the home and  
32 community-based services (HCS) waiver program and the  
33 deaf-blind with multiple disabilities (DBMD) waiver  
34 program; and

35 (D) subject to Subdivision (2), the  
36 residential services provided under an ICF-IID  
37 program, the home and community-based services (HCS)  
38 waiver program, and the deaf-blind with multiple  
39 disabilities (DBMD) waiver program; and

40 (2) a process for evaluating and  
41 determining the feasibility and cost efficiency of  
42 transitioning residential services described by  
43 Subdivision (1)(D) to a Medicaid managed care model  
44 that is based on an evaluation of a separate pilot  
45 program conducted by the commission, in consultation  
46 and collaboration with the advisory committee, that  
47 operates after the transition process described by  
48 Subdivision (1).

49 (c) Before implementing the transition  
50 described by Subsection (b), the commission shall,  
51 subject to Subsection (g), determine whether to:

52 (1) continue operation of the Medicaid  
53 waiver programs or ICF-IID program only for purposes  
54 of providing, if applicable:

55 (A) supplemental long-term services  
56 and supports not available under the managed care  
57 program delivery model selected by the commission; or

58 (B) long-term services and supports  
59 to Medicaid waiver program recipients who choose to  
60 continue receiving benefits under the waiver programs  
61 as provided by Subsection (g); or

62 (2) provide all or a portion of the

1 long-term services and supports previously available  
2 under the Medicaid waiver programs or ICF-IID program  
3 through the managed care program delivery model  
4 selected by the commission.

5 (d) In implementing the transition described by  
6 Subsection (b), the commission shall develop a process  
7 to receive and evaluate input from interested  
8 statewide stakeholders that is in addition to the  
9 input provided by the advisory committee.

10 (e) The commission shall ensure that there is a  
11 comprehensive plan for transitioning the provision of  
12 Medicaid benefits under this section that protects the  
13 continuity of care provided to individuals to whom  
14 this section applies and ensures individuals have a  
15 choice among acute care and comprehensive long-term  
16 services and supports providers and service delivery  
17 options, including the consumer direction model.

18 (f) Before transitioning the provision of  
19 Medicaid benefits for children under this section, a  
20 managed care organization providing services under the  
21 managed care program delivery model selected by the  
22 commission must demonstrate to the satisfaction of the  
23 commission that the organization's network of  
24 providers has experience and expertise in the  
25 provision of services to children with an intellectual  
26 or developmental disability. Before transitioning  
27 the provision of Medicaid benefits for adults with an  
28 intellectual or developmental disability under this  
29 section, a managed care organization providing  
30 services under the managed care program delivery model  
31 selected by the commission must demonstrate to the  
32 satisfaction of the commission that the organization's  
33 network of providers has experience and expertise in  
34 the provision of services to adults with an  
35 intellectual or developmental disability.

#### 36 Revisor's Note

37 Sections 534.202(b) and (c), Government Code,  
38 provide that "[s]ubject to Subsection (g)" of Section  
39 534.202, Government Code, the Health and Human  
40 Services Commission shall carry out certain duties.  
41 The revised law omits the quoted phrase because the  
42 requirements of Subsection (g), which is revised in  
43 this chapter as Section 542.0202(a), apply by their  
44 own terms, and a separate statement to that effect is  
45 unnecessary.

#### 46 Revised Law

47 Sec. 542.0202. RECIPIENT CHOICE OF DELIVERY MODEL. (a) If  
48 the commission determines under Section 542.0201(c)(2) that all or  
49 a portion of the long-term services and supports previously  
50 available under Medicaid waiver programs should be provided through  
51 a managed care program delivery model, the commission shall, at the

1 time of the transition, allow each recipient receiving long-term  
2 services and supports under a Medicaid waiver program the option  
3 of:

4 (1) continuing to receive the services and supports  
5 under the Medicaid waiver program; or

6 (2) receiving the services and supports through the  
7 managed care program delivery model the commission selects.

8 (b) A recipient who chooses under Subsection (a) to receive  
9 long-term services and supports through a managed care program  
10 delivery model may not subsequently choose to receive the services  
11 and supports under a Medicaid waiver program. (Gov. Code, Secs.  
12 534.202(g), (h).)

13 Source Law

14 (g) If the commission determines that all or a  
15 portion of the long-term services and supports  
16 previously available under the Medicaid waiver  
17 programs should be provided through a managed care  
18 program delivery model under Subsection (c)(2), the  
19 commission shall, at the time of the transition, allow  
20 each recipient receiving long-term services and  
21 supports under a Medicaid waiver program the option  
22 of:

23 (1) continuing to receive the services and  
24 supports under the Medicaid waiver program; or

25 (2) receiving the services and supports  
26 through the managed care program delivery model  
27 selected by the commission.

28 (h) A recipient who chooses to receive long-term  
29 services and supports through a managed care program  
30 delivery model under Subsection (g) may not, at a later  
31 time, choose to receive the services and supports  
32 under a Medicaid waiver program.

33 Revised Law

34 Sec. 542.0203. REQUIRED CONTRACT PROVISIONS. In addition  
35 to the requirements of \_\_\_\_ [[[Section 533.005]]], a contract  
36 between a managed care organization and the commission for the  
37 organization to provide Medicaid benefits under Section 542.0201  
38 must contain a requirement that the organization implement a  
39 process for individuals with an intellectual or developmental  
40 disability that:

41 (1) ensures that the individuals have a choice among  
42 acute care and comprehensive long-term services and supports  
43 providers and service delivery options, including the consumer

1 direction model;

2 (2) to the greatest extent possible, protects those  
3 individuals' continuity of care with respect to access to primary  
4 care providers, including through the use of single-case agreements  
5 with out-of-network providers; and

6 (3) provides access to a member services telephone  
7 line for individuals or their legally authorized representatives to  
8 obtain information on and assistance with accessing services  
9 through network providers, including providers of primary and  
10 specialty services and other long-term services and supports. (Gov.  
11 Code, Sec. 534.202(i).)

12 Source Law

13 (i) In addition to the requirements of Section  
14 533.005, a contract between a managed care  
15 organization and the commission for the organization  
16 to provide Medicaid benefits under this section must  
17 contain a requirement that the organization implement  
18 a process for individuals with an intellectual or  
19 developmental disability that:

20 (1) ensures that the individuals have a  
21 choice among acute care and comprehensive long-term  
22 services and supports providers and service delivery  
23 options, including the consumer direction model;

24 (2) to the greatest extent possible,  
25 protects those individuals' continuity of care with  
26 respect to access to primary care providers, including  
27 the use of single-case agreements with out-of-network  
28 providers; and

29 (3) provides access to a member services  
30 phone line for individuals or their legally authorized  
31 representatives to obtain information on and  
32 assistance with accessing services through network  
33 providers, including providers of primary, specialty,  
34 and other long-term services and supports.

35 Revisor's Note

36 Section 534.202(i), Government Code, refers to a  
37 contract for a managed care organization to provide  
38 Medicaid benefits under "this section," meaning  
39 Section 534.202, Government Code. The provisions of  
40 Section 534.202 relating to the provision of Medicaid  
41 benefits by a managed care organization are revised in  
42 this chapter as Section 542.0201, and the revised law  
43 is drafted accordingly.

1 Revised Law

2 Sec. 542.0204. RESPONSIBILITIES OF COMMISSION UNDER  
3 SUBCHAPTER. In administering this subchapter, the commission shall  
4 ensure, on making a determination to transition services under  
5 Section 542.0201:

6 (1) that the commission is responsible for setting the  
7 minimum reimbursement rate paid to an ICF-IID services or group  
8 home provider under the integrated managed care system, including  
9 the staff rate enhancement paid to an ICF-IID services or group home  
10 provider;

11 (2) that an ICF-IID services or group home provider is  
12 paid not later than the 10th day after the date the provider submits  
13 a clean claim in accordance with the criteria the commission uses to  
14 reimburse an ICF-IID services or group home provider, as  
15 applicable;

16 (3) the establishment of an electronic portal through  
17 which an ICF-IID services or group home provider participating in  
18 the STAR+PLUS Medicaid managed care program delivery model or the  
19 most appropriate integrated capitated managed care program  
20 delivery model, as appropriate, may submit long-term services and  
21 supports claims to any participating managed care organization; and

22 (4) that the consumer direction model is an available  
23 option for each individual with an intellectual or developmental  
24 disability who receives Medicaid benefits in accordance with this  
25 subchapter to achieve self-determination, choice, and control and  
26 that the individual or the individual's legally authorized  
27 representative has access to a comprehensive, facilitated,  
28 person-centered plan that identifies outcomes for the individual.  
29 (Gov. Code, Sec. 534.203.)

30 Source Law

31 Sec. 534.203. RESPONSIBILITIES OF COMMISSION  
32 UNDER SUBCHAPTER. In administering this subchapter,  
33 the commission shall ensure, on making a determination  
34 to transition services under Section 534.202:

35 (1) that the commission is responsible for  
36 setting the minimum reimbursement rate paid to a  
37 provider of ICF-IID services or a group home provider

1 under the integrated managed care system, including  
2 the staff rate enhancement paid to a provider of  
3 ICF-IID services or a group home provider;

4 (2) that an ICF-IID service provider or a  
5 group home provider is paid not later than the 10th day  
6 after the date the provider submits a clean claim in  
7 accordance with the criteria used by the commission  
8 for the reimbursement of ICF-IID service providers or  
9 a group home provider, as applicable;

10 (3) the establishment of an electronic  
11 portal through which a provider of ICF-IID services or  
12 a group home provider participating in the STAR+PLUS  
13 Medicaid managed care program delivery model or the  
14 most appropriate integrated capitated managed care  
15 program delivery model, as appropriate, may submit  
16 long-term services and supports claims to any  
17 participating managed care organization; and

18 (4) that the consumer direction model is  
19 an available option for each individual with an  
20 intellectual or developmental disability who receives  
21 Medicaid benefits in accordance with this subchapter  
22 to achieve self-determination, choice, and control,  
23 and that the individual or the individual's legally  
24 authorized representative has access to a  
25 comprehensive, facilitated, person-centered plan that  
26 identifies outcomes for the individual.

27 Revisor's Note

28 Section 534.203, Government Code, refers to the  
29 Health and Human Services Commission making a  
30 determination to transition services under "Section  
31 534.202," Government Code. The provisions of Section  
32 534.202 relating to making a determination to  
33 transition services are revised as Section 542.0201 of  
34 this chapter, and the revised law is drafted  
35 accordingly.